

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

VANCE *Layne* HYATT

2. DATE
OF
DEATH

August 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY
Harford

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

~~Bel Air~~ *Balto* 9-03

D. STREET ADDRESS (If rural, give location)

3605 Ednor Road

c. Length of stay in Baltimore

11

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 24 1912

9. AGE (In years last birthday)

38

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sound System

10B. KIND OF BUSINESS OR INDUSTRY

Pres. of Corp

11. BIRTHPLACE (State or foreign country)

New Mexico

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

L. E. Hyatt

14. MOTHER'S MAIDEN NAME

Leona Howell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

World War II

16. SOCIAL SECURITY NO.

527-10-3636

17. INFORMANT

Insurance L Hyatt

ADDRESS

same

16. *E902.6*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Fracture of skull*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Gymnasium

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Bel Air High School, Bel Air, Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 11, 1950

21E. INJURY OCCURRED

WHILE AT WORK ☒

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Lost Balance and Fell from Scaffold

22. I certify that I took charge of the remains described above, held an *Insp. & Inquiry* thereon and from *Autopsy, Inspection or Inquiry* the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. ...

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

8-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 14/50

24C. NAME OF CEMETERY OR CREMATORY

Leidys

24D. LOCATION (City, town, or county)

Souderton Pa

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Henry W. Jenkins

25. FUNERAL DIRECTOR

ADDRESS

Henry W. Jenkins, no 6 4905 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly stated. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly. The supplied. The

STATE OF NEW YORK
CERTIFICATE OF DEATH

| | | | |
|------------------------|--|-------------------------------|--|
| Name of Deceased | | Date of Death | |
| Place of Birth | | Date of Birth | |
| Sex | | Race | |
| Marital Status | | Cause of Death | |
| Occupation | | Place of Death | |
| Signature of Physician | | Signature of Registrar | |
| Signature of Coroner | | Signature of Medical Examiner | |

| | | | |
|------------------------|--|-------------------------------|--|
| Name of Deceased | | Date of Death | |
| Place of Birth | | Date of Birth | |
| Sex | | Race | |
| Marital Status | | Cause of Death | |
| Occupation | | Place of Death | |
| Signature of Physician | | Signature of Registrar | |
| Signature of Coroner | | Signature of Medical Examiner | |

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Sister Mary Dominica Connor

2. DATE
OF
DEATH

8/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE Md.

B. COUNTY _____ before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION5512 Roland Ave
Monastery of the Visitation

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Maryland

D. STREET ADDRESS (If rural, give location)

5712 Roland Ave.

27-13

c. Length of stay in Baltimore

30 years

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 25, 1864

9. AGE (in years
last birthday)

86

10. Under 1 Year
Months: Days

2

19

11. Under 24 Hours
Hours: Min.

-

-

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Religious

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Norristown, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Connor

14. MOTHER'S MAIDEN NAME

Mary Wogon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, oo or uokooow) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mother Marie Aimee Gallagher

18.

464X

CAUSE OF DEATH 5712 Roland Ave.

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary embolism

DUE TO

16 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Pulvic thrombophlebitis

DUE TO

1 month

(C) Senil. 17

10 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 1940 to Aug 12, 1950. At I last saw the
deceased alive on Aug 8, 1950, and that death occurred at 1 4 m., from the causes and on the date stated above.

23A. SIGNATURE

Charles D. Connor

M. D.

23B. ADDRESS

852 Reed St

23C. DATE SIGNED

8-13-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

August 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

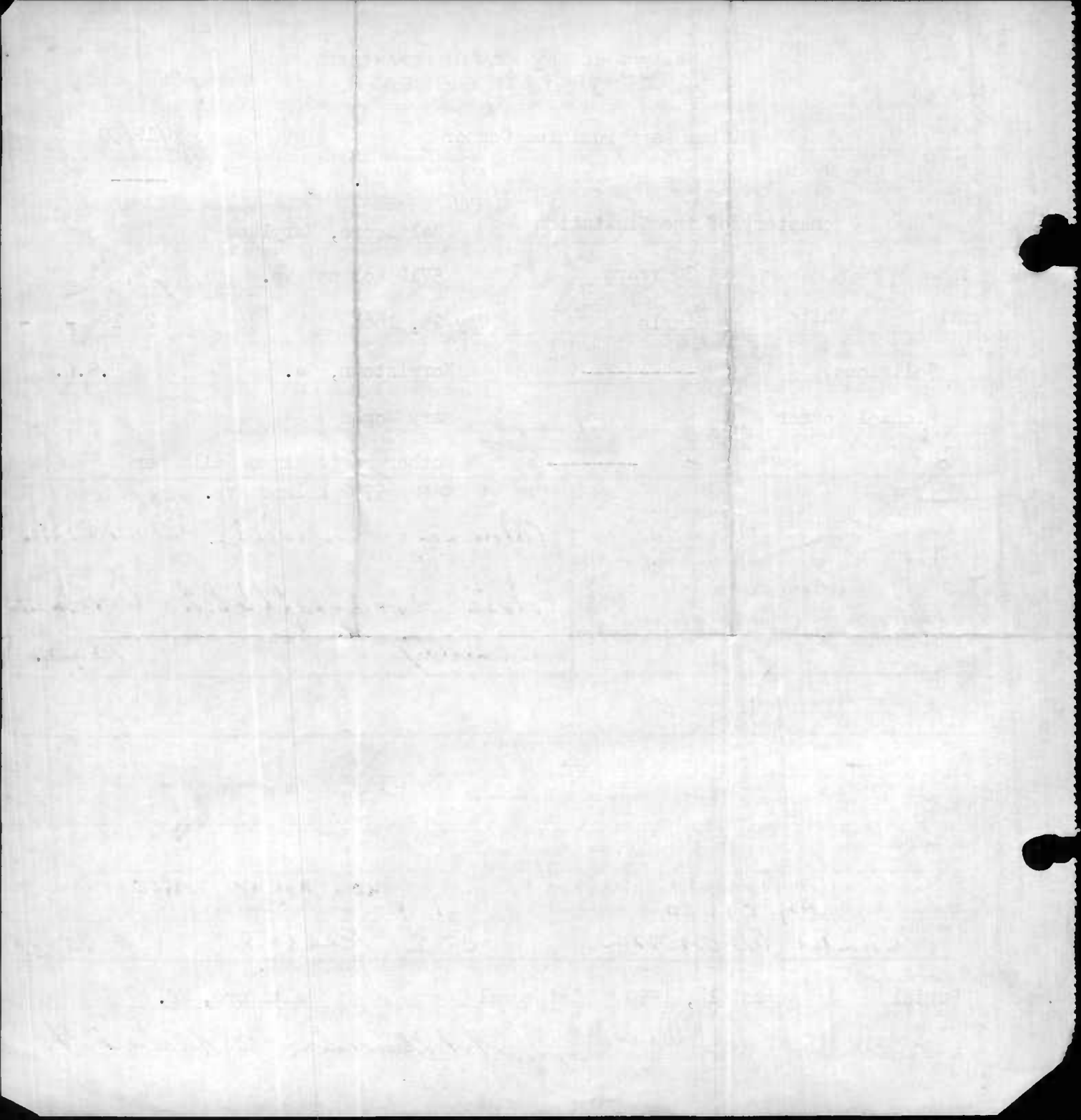
25. FUNERAL DIRECTOR

ADDRESS

H. H. Meier & Son 805 N. Calvert St.

AUG 13 1950

100 B



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 7003
M-460 JL-140229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7003
Registered No.

| | | | | | |
|---|----------------------------------|---|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Harry Mallory (Mallory) | | 2. DATE OF DEATH 8-13-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Catonsville | | | |
| c. Length of stay in Baltimore 2 mos. | | D. STREET ADDRESS (If rural, give location) 12 Osborn Ave. Catonsville 5300 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Mar 22, 1904 | 9. AGE (in years last birthday) 46 | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOATWORKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 13. FATHER'S NAME Henry Mallory | | 14. MOTHER'S MAIDEN NAME Evelyn Gris tbur | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS B. C. H. Records, 4940 Eastern Ave. | |
| 18. 162x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. PRIMARY BRONCHOPULMONARY CARCINOMA? (OVER) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 7 Wks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 7-30-50 , to Aug. 13, 1950 , that I last saw the deceased alive on Aug. 13, 1950 , and that death occurred at 6am m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE [Signature] M. D. | | 23B. ADDRESS 4940 Eastern Ave. | | 23C. DATE SIGNED Aug. 13, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 16, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Maple Grove | |
| 24D. LOCATION (City, town, or county) Cleves, Ohio | | 25. FUNERAL DIRECTOR Wm. J. Tiekner & Sons - Balto, Md. | | ADDRESS | |

See Document File 50-7003

9.5.50

20

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EMILY B. COLSTON

2. DATE
OF
DEATH

8-11-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Anderson Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2610 Elsinor Ave

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 12, 1859

9. AGE (In years last birthday)

90

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel R. Bandell

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. Wm. W. Bandell 2565 W. Baltimore St.

18.

153X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinomatosis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma of Colon

DUE TO

(C)

Generalized Arteriosclerosis?
SenilityII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8-1-1950 to 8-11-1950 that I last saw the deceased alive on 8-11-1950, and that death occurred at 12:45 p.m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/14/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Pk

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MINISTRE DE LA SANTE
CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|-----------------------------|--|---------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | |
| 4. Date of death | | 5. Time of death | | 6. Place of death | |
| 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | |
| 10. Signature of registrar | | 11. Signature of witness | | 12. Signature of coroner | |
| 13. Signature of funeral director | | 14. Signature of undertaker | | 15. Signature of cemetery | |
| 16. Signature of burial place | | 17. Signature of interment | | 18. Signature of burial | |
| 19. Signature of burial | | 20. Signature of burial | | 21. Signature of burial | |
| 22. Signature of burial | | 23. Signature of burial | | 24. Signature of burial | |
| 25. Signature of burial | | 26. Signature of burial | | 27. Signature of burial | |
| 28. Signature of burial | | 29. Signature of burial | | 30. Signature of burial | |
| 31. Signature of burial | | 32. Signature of burial | | 33. Signature of burial | |
| 34. Signature of burial | | 35. Signature of burial | | 36. Signature of burial | |
| 37. Signature of burial | | 38. Signature of burial | | 39. Signature of burial | |
| 40. Signature of burial | | 41. Signature of burial | | 42. Signature of burial | |
| 43. Signature of burial | | 44. Signature of burial | | 45. Signature of burial | |
| 46. Signature of burial | | 47. Signature of burial | | 48. Signature of burial | |
| 49. Signature of burial | | 50. Signature of burial | | 51. Signature of burial | |
| 52. Signature of burial | | 53. Signature of burial | | 54. Signature of burial | |
| 55. Signature of burial | | 56. Signature of burial | | 57. Signature of burial | |
| 58. Signature of burial | | 59. Signature of burial | | 60. Signature of burial | |
| 61. Signature of burial | | 62. Signature of burial | | 63. Signature of burial | |
| 64. Signature of burial | | 65. Signature of burial | | 66. Signature of burial | |
| 67. Signature of burial | | 68. Signature of burial | | 69. Signature of burial | |
| 70. Signature of burial | | 71. Signature of burial | | 72. Signature of burial | |
| 73. Signature of burial | | 74. Signature of burial | | 75. Signature of burial | |
| 76. Signature of burial | | 77. Signature of burial | | 78. Signature of burial | |
| 79. Signature of burial | | 80. Signature of burial | | 81. Signature of burial | |
| 82. Signature of burial | | 83. Signature of burial | | 84. Signature of burial | |
| 85. Signature of burial | | 86. Signature of burial | | 87. Signature of burial | |
| 88. Signature of burial | | 89. Signature of burial | | 90. Signature of burial | |
| 91. Signature of burial | | 92. Signature of burial | | 93. Signature of burial | |
| 94. Signature of burial | | 95. Signature of burial | | 96. Signature of burial | |
| 97. Signature of burial | | 98. Signature of burial | | 99. Signature of burial | |
| 100. Signature of burial | | 101. Signature of burial | | 102. Signature of burial | |

H-630
50 7005HART
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7005
Registered No.

| | |
|---|--|
| BIRTH NO. 22 | |
| 1. NAME OF DECEASED (Type or Print) <i>Jeffery Hart</i> | |
| 2. DATE OF DEATH <i>August 11, 1950</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>S.C.</i> B. COUNTY <i>V-37</i> | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Pickens</i> | |
| D. STREET ADDRESS (If rural, give location) | |
| c. Length of stay in Baltimore <i>4 days</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i> | 8. DATE OF BIRTH <i>8-2-49</i> |
| 9. AGE (in years last birthday) <i>1</i> | 10. UNDER 1 Year Months: Days: <i>11</i> |
| 11. UNDER 24 Hours Hours: Min. | 12. CITIZEN OF WHAT COUNTRY? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country) <i>Anderson, S.C.</i> | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <i>Gordon C. Hart</i> | 14. MOTHER'S MAIDEN NAME <i>Elaine Bixby</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
| 17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> | ADDRESS |

| | | |
|---|---|----------------------------------|
| 18. <i>754.4</i> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <i>Congenital Heart Disease, Cyanotic</i> | <i>birth -</i> |
| ANTECEDENT CAUSES | (B) <i>Atresia of the Tricuspid Valve</i> | <i>birth -</i> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (C) <i>Cerebral Anoxia</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|--|--|
| 19A. DATE OF OPERATION <i>8-11</i> | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <i>8-11</i> , 1950, to <i>8-11</i> , 1950, that I last saw the deceased alive on <i>8-11</i> , 1950, and that death occurred at <i>8:26 p.m.</i> , from the causes and on the date stated above. | | |
| 23A. SIGNATURE <i>Edward Winslow Hopkin M.D.</i> | 23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i> | 23C. DATE SIGNED <i>8-12-50</i> |

| | | | |
|--|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | 24B. DATE <i>Aug. 13, 50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i> | 24D. LOCATION (City, town, or county) (State) <i>Ayer, Mass.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 14 1950</i> | REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>Henry Sander & Sons, Inc.</i> | ADDRESS <i>157 E George Street</i> |

1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a description of the methods used in the investigation. The results of the study are then presented in a series of tables and figures. The final part of the report is a discussion of the results and their implications for the field of study.

2. The second part of the report is a detailed description of the methods used in the investigation. This includes a description of the subjects, the materials, and the procedures used. It also includes a description of the data collection and analysis methods.

3. The third part of the report is a presentation of the results of the study. This is done in a series of tables and figures. The tables show the raw data, and the figures show the results of the statistical analysis.

4. The fourth part of the report is a discussion of the results and their implications for the field of study. This includes a comparison of the results with previous studies, a discussion of the strengths and limitations of the study, and a discussion of the implications for future research.

5. The fifth part of the report is a conclusion. This is a brief statement of the main findings of the study and their implications for the field of study.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7008

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Herbert W. Bates

2. DATE
OF
DEATHAug 13th 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

19-03

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

111 S Calhoun St

C. CITY OR TOWN (If outside corporate limits, write LOCAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

111 S Calhoun St

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work during most of working life, if any)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.0 002X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary occlusion

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) DUE TO

Pulmonary tuberculosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

8-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 14 1950

VS 151

5443L

13B

RECEIVED
MAY 10 1964



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

5-120

50 7007

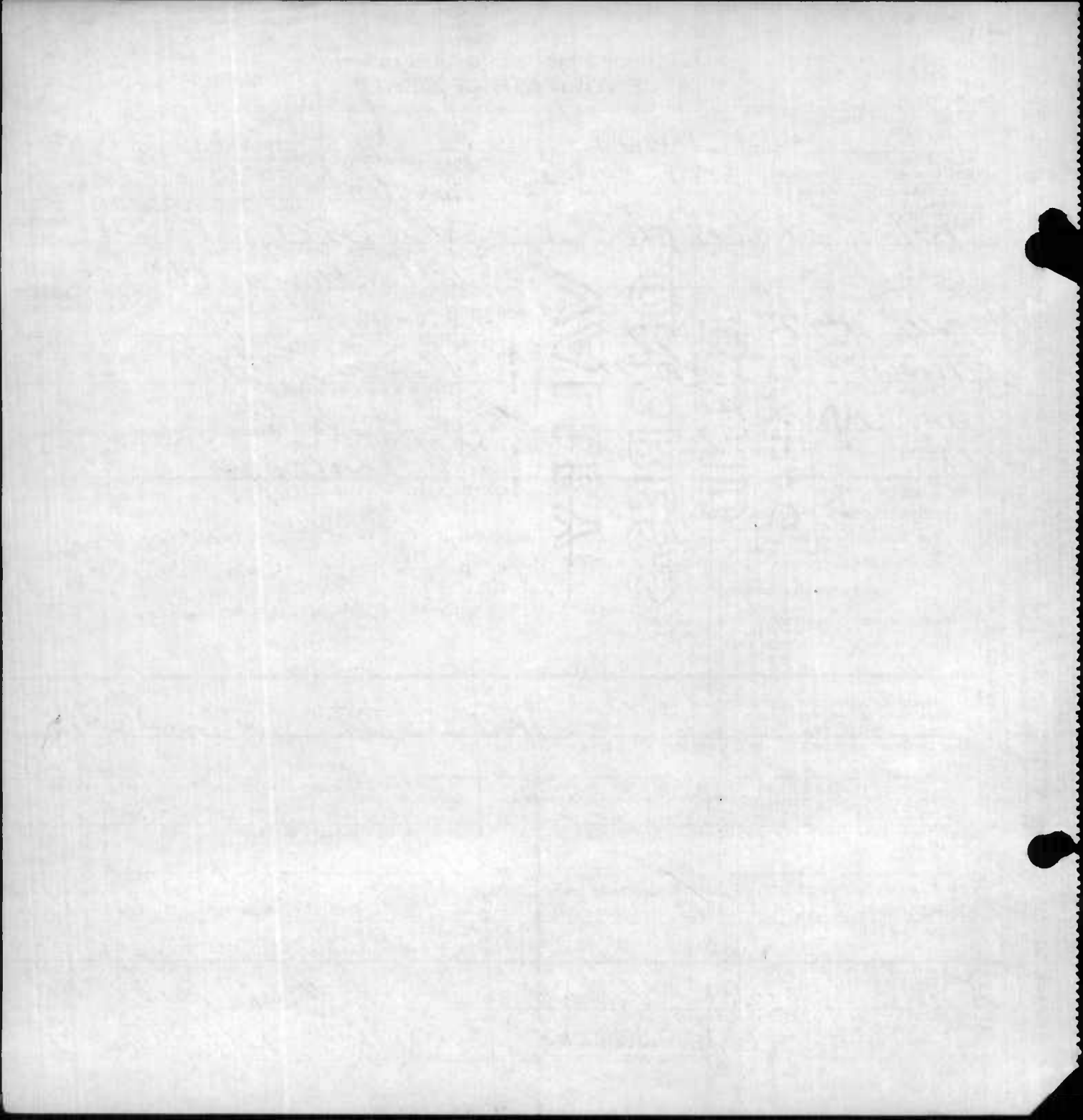
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7007

Registered No. _____

| | | | | | |
|--|-------------------------------|--|--|--|---------------------------------------|
| BIRTH NO. _____ | | 1. NAME OF DECEASED (Type or Print) ALICE BLANCHE DE BUYS | | 2. DATE OF DEATH AUGUST 12 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 1318 LINDEN AVE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland | | B. COUNTY _____ | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 1318 Linden Ave | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 1318 Linden Ave | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | 8. DATE OF BIRTH SEPTEMBER 2 1913 | | 9. AGE (in years last birthday) 36 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 11. BIRTHPLACE (State or foreign country) Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY? _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 14. MOTHER'S MAIDEN NAME Minerva Kidd | |
| 13. FATHER'S NAME John Hoshall | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT Malcolm De Buys | | ADDRESS _____ | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 18. 420.0 I | | CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | |
| DUE TO (A) Arteriosclerotic type heart disease, with hyper-trophy, myocardial degeneration & congestive heart failure. | | DUE TO (B) Generalized arteriosclerosis. | | DUE TO (C) _____ | |
| ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic ulcerative colitis (bacterial origin undetermined) | |
| 19A. DATE OF OPERATION none | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from May 1 , 19 50 , to Aug 12 , 19 50 , that I last saw the deceased alive on Aug 12 , 19 50 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Wm. Michel | | 23B. ADDRESS 1015 Poplar Grove St | | 23C. DATE SIGNED Aug 13 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/15/50 | | 24C. NAME OF CEMETERY OR CREMATORY Green Mount | |
| 24D. LOCATION (City, town, or county) (State) Green Mount Baltimore Md | | 25. FUNERAL DIRECTOR McCook Inc | | ADDRESS 1217 St Paul St | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | VS 150 | |

931



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7008

| | | | | | |
|--|---|--|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MYRTLE B SMITH | | 2. DATE OF DEATH 8-12-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Harford | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital | | D. STREET ADDRESS (If rural, give location) 6200 | | Yrs. Mos. Days | |
| c. Length of stay in Baltimore | 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH Aug. 14, 1883 | 9. AGE (In years last birthday) 67 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Cornelius B. Smith | | 14. MOTHER'S MAIDEN NAME Amelia Miller | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) W (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Dr. C. B. Martin, 4318 Springwood Ave | | ADDRESS | |
| 18. 204.2 CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Mononucleosis leucemica | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Pneumonia | | DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION 2 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug 1 , 19 50 to Aug 12 , 19 50 that I last saw the deceased alive on Aug 12 , 19 50 , and that death occurred at 2:15 A.M., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Eleanor W. Demarest | | 23B. ADDRESS University Hospital | | 23C. DATE SIGNED 8-12-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE 8/15/50 | | 24C. NAME OF CEMETERY OR CREMATORY London Park | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. LOCATION (State) MD | | 25. FUNERAL DIRECTOR W. C. Cook | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1950 | | REGISTRAR'S SIGNATURE W. C. Cook | | ADDRESS 1219 St Paul St | |

CERTIFICATE OF DEATH

1



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7009

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Greta Margo Storm (Engstrom)

2. DATE
OF
DEATH

8-9-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTE location)

Baltimore City Hospitals

4940 Eastern Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

11-02

D. STREET ADDRESS (If rural, give location)

1206 N. Charles Street, Apt. 6

c. Length of stay in Baltimore

15 Yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 25, 1905

9. AGE (in years
last birthday)

45

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sweden

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Storm (D)

14. MOTHER'S MAIDEN NAME

Selma Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records* Balto. City Hospitals Eastern Ave

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hepatic Insufficiency

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

1 1/2 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

5 Days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-26, 1950, to 8-9, 1950, that I last saw the
deceased alive on 8-9, 1950, and that death occurred at 4:00 P., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Jogen

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED
Aug. 12, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/14/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peter's

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

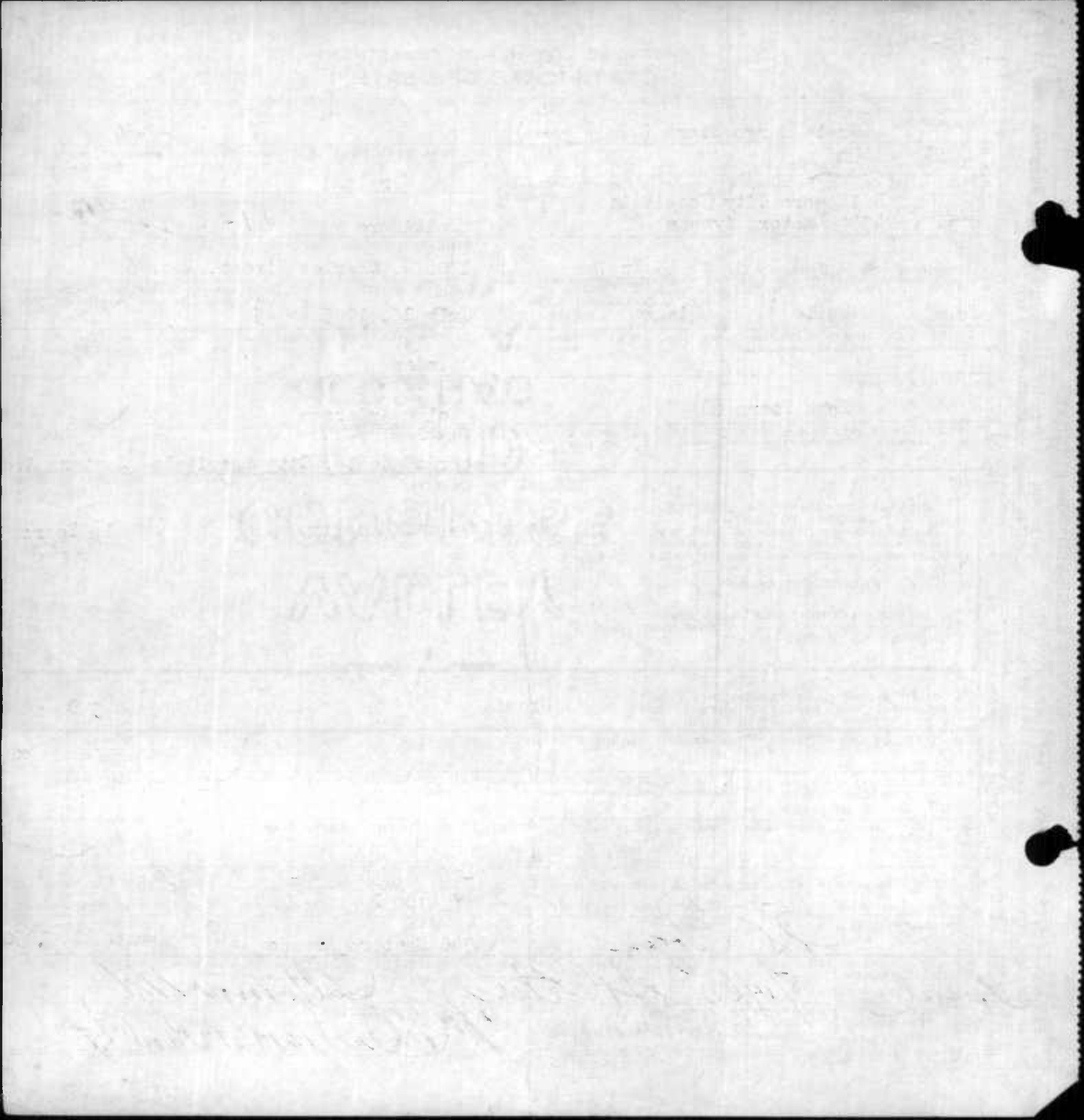
ADDRESS

1214 St Paul St

AUG 14 1950

VS 150

125B



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. _____ | |
|--|----------------------------------|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. _____ | | | | | |
| 1. NAME OF DECEASED (Type or Print) AGNES R. BATZER | | | 2. DATE OF DEATH Aug. 11, 1950 | | |
| 3. PLACE OF DEATH: a. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY _____ | | |
| b. FULL NAME OF HOSPITAL OR INSTITUTION 1307 N. Broadway | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | | d. STREET ADDRESS (If rural, give location) 1307 N. Broadway | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov. 19, 1884 | 9. AGE (In years last birthday) 65 | 10. Under 1 Year Months: _____ Days: _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | |
| 13. FATHER'S NAME Francis R. Kreis | | | 14. MOTHER'S MAIDEN NAME Annie Mueller | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. _____ | | |
| 17. INFORMANT J. Albert Kreis, 1307 N. Broadway | | | ADDRESS _____ | | |
| 18. 416X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Renal Cauditis DUE TO (B) Chorea DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 5 1/2 years | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19a. DATE OF OPERATION 8/14/50 | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Oct. 20, 1944 to Aug. 11, 1950 , that I last saw the deceased alive on Aug. 10, 1950 , and that death occurred at Baltimore, Md. from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE Wm. Hekmat | | 23b. ADDRESS 701 N. Kenard Ave. | | 23c. DATE SIGNED 8/12/50 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 24b. DATE 8/14/50 | | 24c. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 24d. LOCATION (City, town, or county) (State) Edmondson | | 25. FUNERAL DIRECTOR 1219 S. Bond St | | ADDRESS _____ | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1950 | | REGISTRAR'S SIGNATURE Thurston Williams, Md | | | |

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7011
Registered No. 50-7011

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Allen

2. DATE
OF
DEATH

Aug. 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Good Samaritan Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

135 N. Exeter Street

C. Length of stay in Baltimore

?

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

?

8. DATE OF BIRTH

?

9. AGE (In years last birthday)

77

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

?

10B. KIND OF BUSINESS OR INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF WHAT COUNTRY?

?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

Mrs. Jackson-27 N. Carey St.

18. **334X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Hemiplegia rt. side**

DUE TO

?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8-3-**, 19 **50** to **8-5-**, 19 **50** that I last saw the deceased alive on **8-3-**, 19 **50**, and that death occurred at **9 P. m.** on the causes and on the date stated above.

23A. SIGNATURE

Wm. P. Johnson, M.D.

23B. ADDRESS

403 Medical Arts Bldg.

23C. DATE SIGNED

Aug 7-1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-11-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

Brooklyn

(State)

DATE RECEIVED BY LOCAL REGISTRAR

8-11-50

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph C. Russ-1200 McCulloh St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information shown is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important. The

supplied. The

WALLEY

1-11-50

W. J. Hoffman

M 263
50 7012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7012
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louisa MACKERT

2. DATE
OF
DEATH

Aug 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

113 N. LUZERNE AVE

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
WIDOWED

8. DATE OF BIRTH

10-24-79

9. AGE (In years last birthday)

70

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Tim

14. MOTHER'S MAIDEN NAME

Elizabeth Schneider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS



18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE AND ARTERIO-DUE TO SCLEROTIC HEART DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) 7
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

BRONCHOPNEUMONIA

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-10, 1950, to 8-11, 1950, that I last saw the deceased alive on 8-11, 1950, and that death occurred at 2:15 a. m., from the causes and on the date stated above.

23A. SIGNATURE

A. H. Owens, Jr. M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Buried

24B. DATE

Aug 14/50

24C. NAME OF CEMETERY OR CREMATORY

Balt Cem

24D. LOCATION (City, town, or county)

Balt

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

William L. Horn 2004 Calver

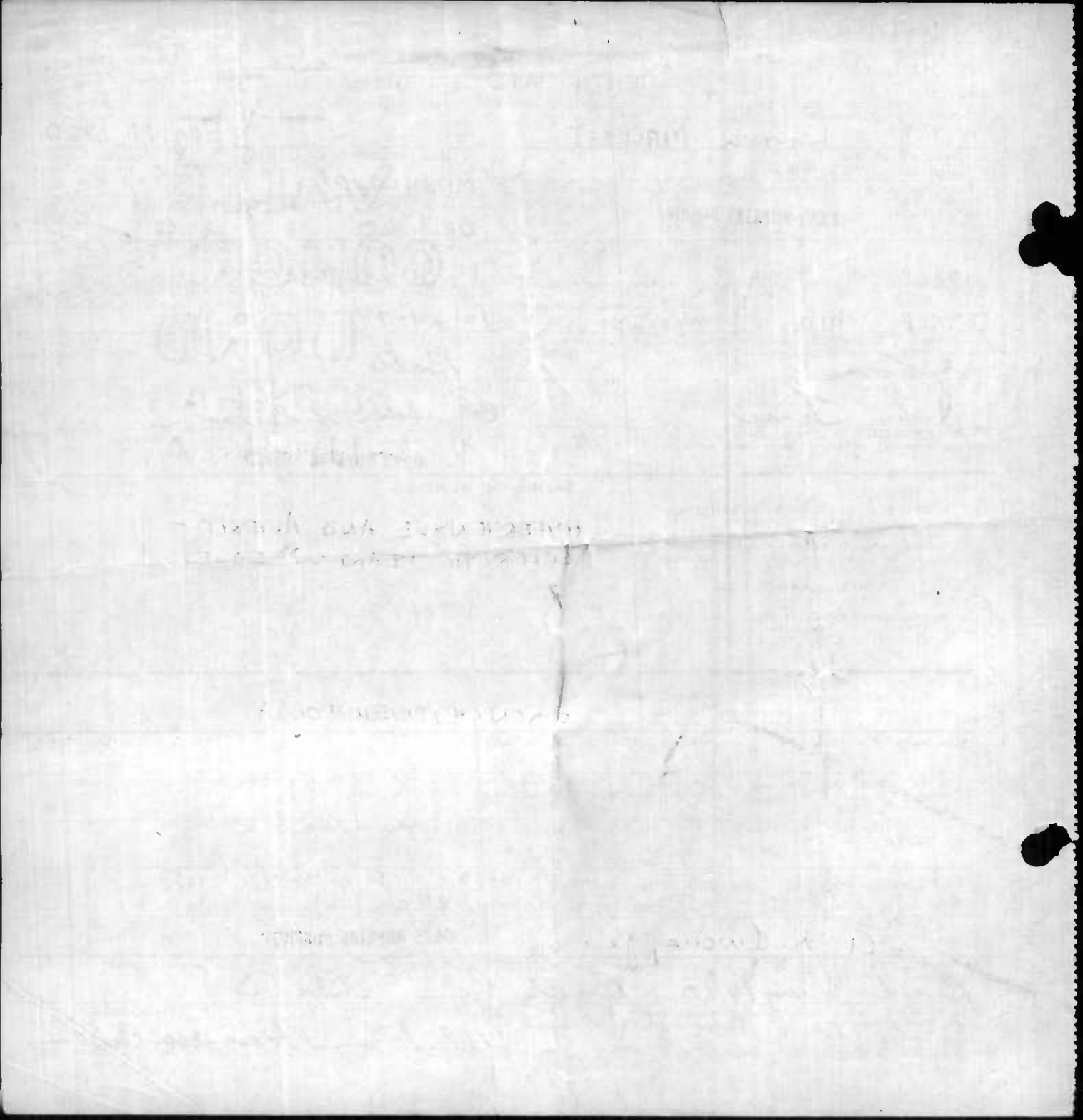
AUG 14 1950

VS 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



M-600

50 7013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7013

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Mohr

2. DATE
OF
DEATH

Aug 11/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

403 N Lakewood

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days
11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George W Townsend

14. MOTHER'S MAIDEN NAME

Elizabeth Metzger

15. WAS DECEASED
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Chas Mohr 403 N Lakewood

18. 760X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Chronic Nephritis

?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hypertensive C. V. D.
Diabetes Mellitus
(C) Atherosclerosis - generalized

1945

?

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 1945, 19 to Aug 11, 1950, that I last saw the
deceased alive on Aug 11, 1950, and that death occurred at 8:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

L. F. Williams

M. D.

23B. ADDRESS

2623 E. Monument St

23C. DATE SIGNED

Aug 12, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

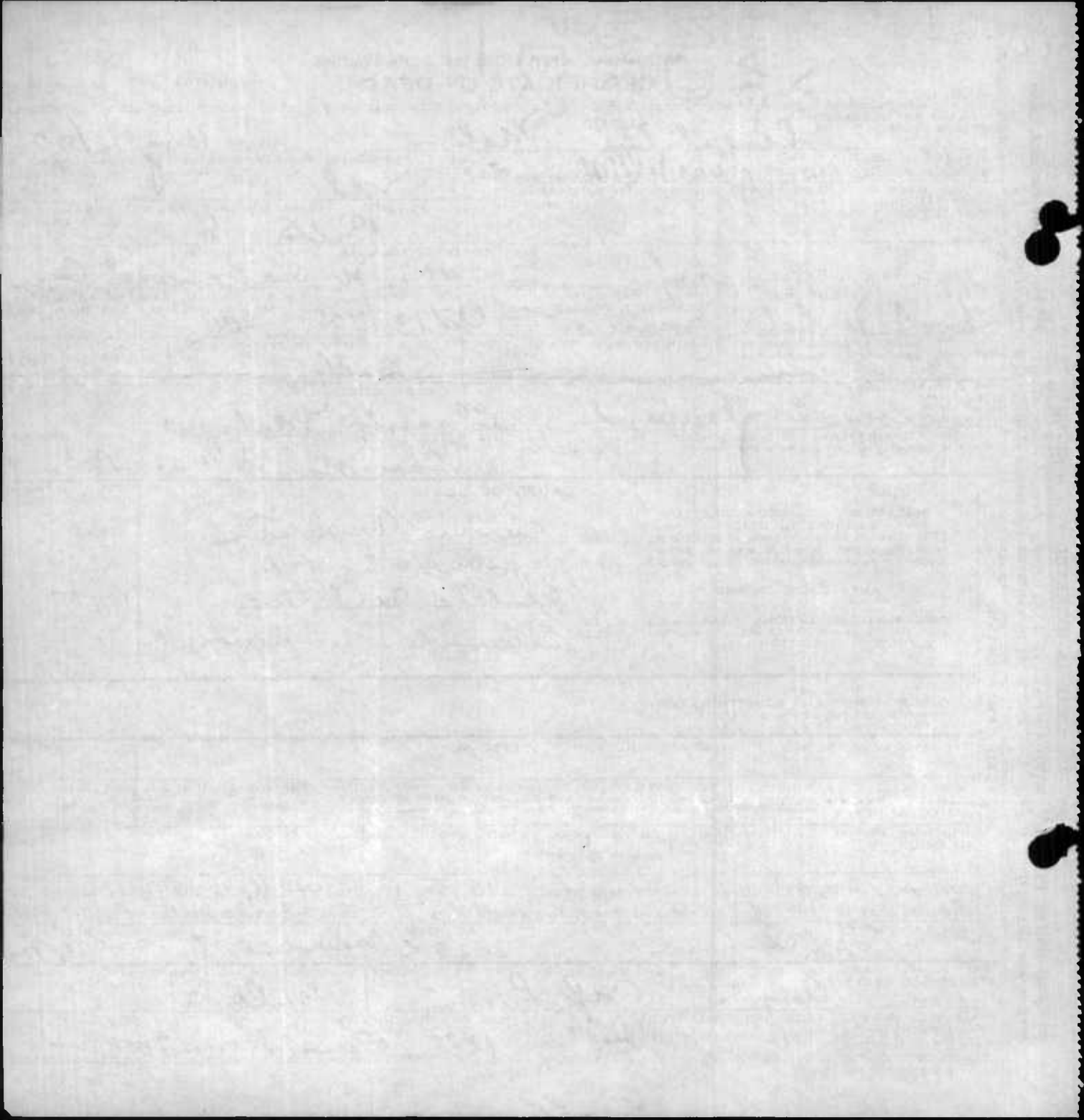
ADDRESS

VS 150

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

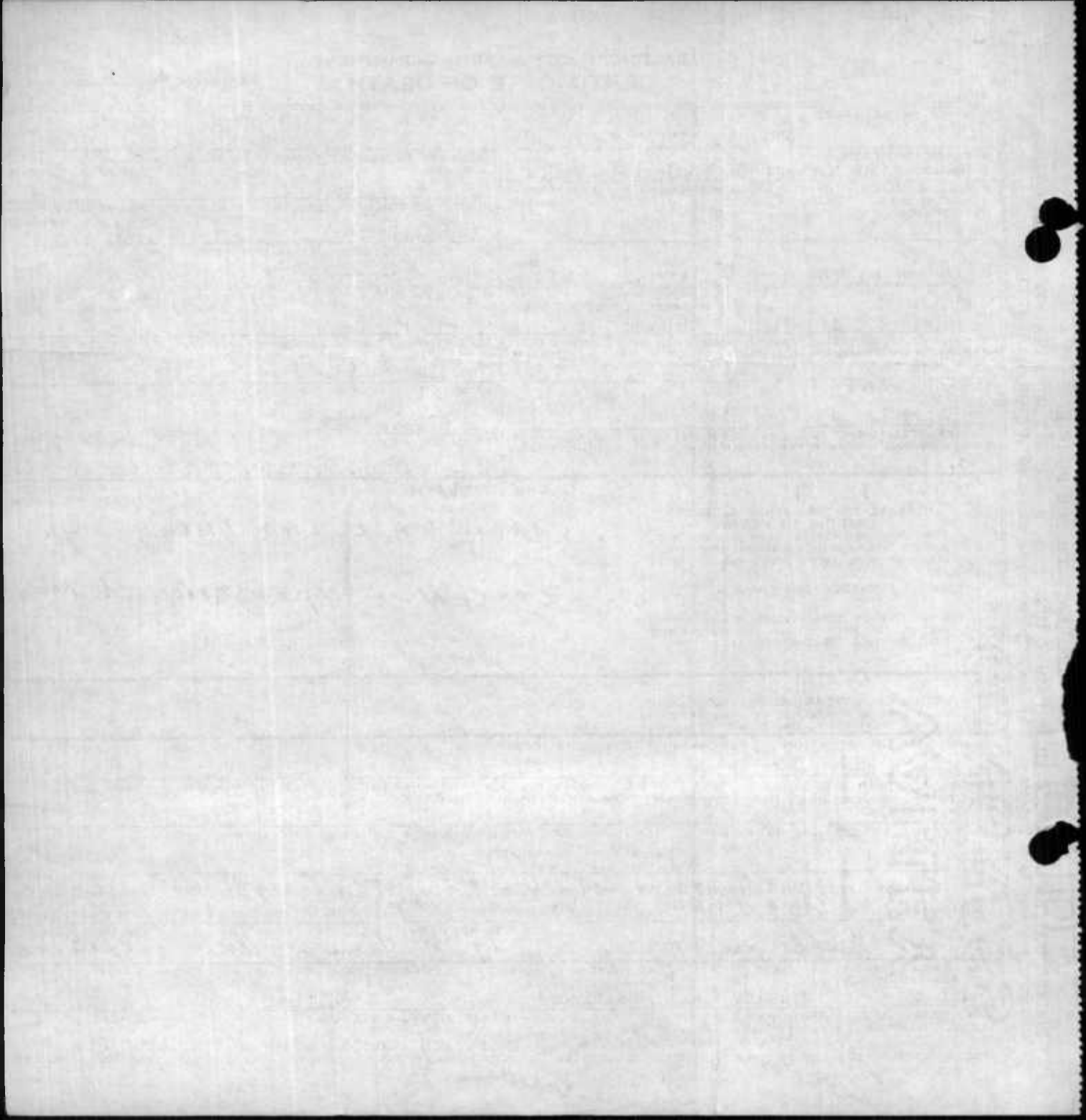
50 7014
Registered No.

BIRTH NO.

| | | | |
|--|----------------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) EMMA M. LINDENSTRUTH | | 2. DATE OF DEATH Aug. 11, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 5605 Woodcrest Ave., | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 00 | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| c. Length of stay in Baltimore Lifetime. | | D. STREET ADDRESS (If rural, give location) 5605 Woodcrest Ave., | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 17, 1863 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 87 |
| 13. FATHER'S NAME Henry Baitz | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME Sophia Lane | |
| 17. INFORMANT | | ADDRESS Mrs. David L. Bruning, 5605 Woodcrest Ave. | |

| | | |
|--|--|---|
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARDIO VASCULAR DISEASE | | INTERVAL BETWEEN ONSET AND DEATH 2 YR'S |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. BROKEN COMPENSATION | | 6 MO'S |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|---|--|--|--|--|--|
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK AT WHILE <input type="checkbox"/> WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug 8, 1950 to Aug 11, 1950 , that I last saw the deceased alive on Aug 11, 1950 and that death occurred at 7 P.M. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE William Frey | | 23B. ADDRESS 1928 Penna - Ave | | 23C. DATE SIGNED 8/12/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 14, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25. FUNERAL DIRECTOR Ullrich Funeral Home | | ADDRESS 2008 Orleans St., | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1950 | | REGISTRAR'S SIGNATURE W. Williams, M.D. | | | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7015

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years, last birthday) Under 1 Year Months Days Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1, 1950 to Aug 8, 1950, that I last saw the deceased alive on Aug 8, 1950, and that death occurred at 10:15 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

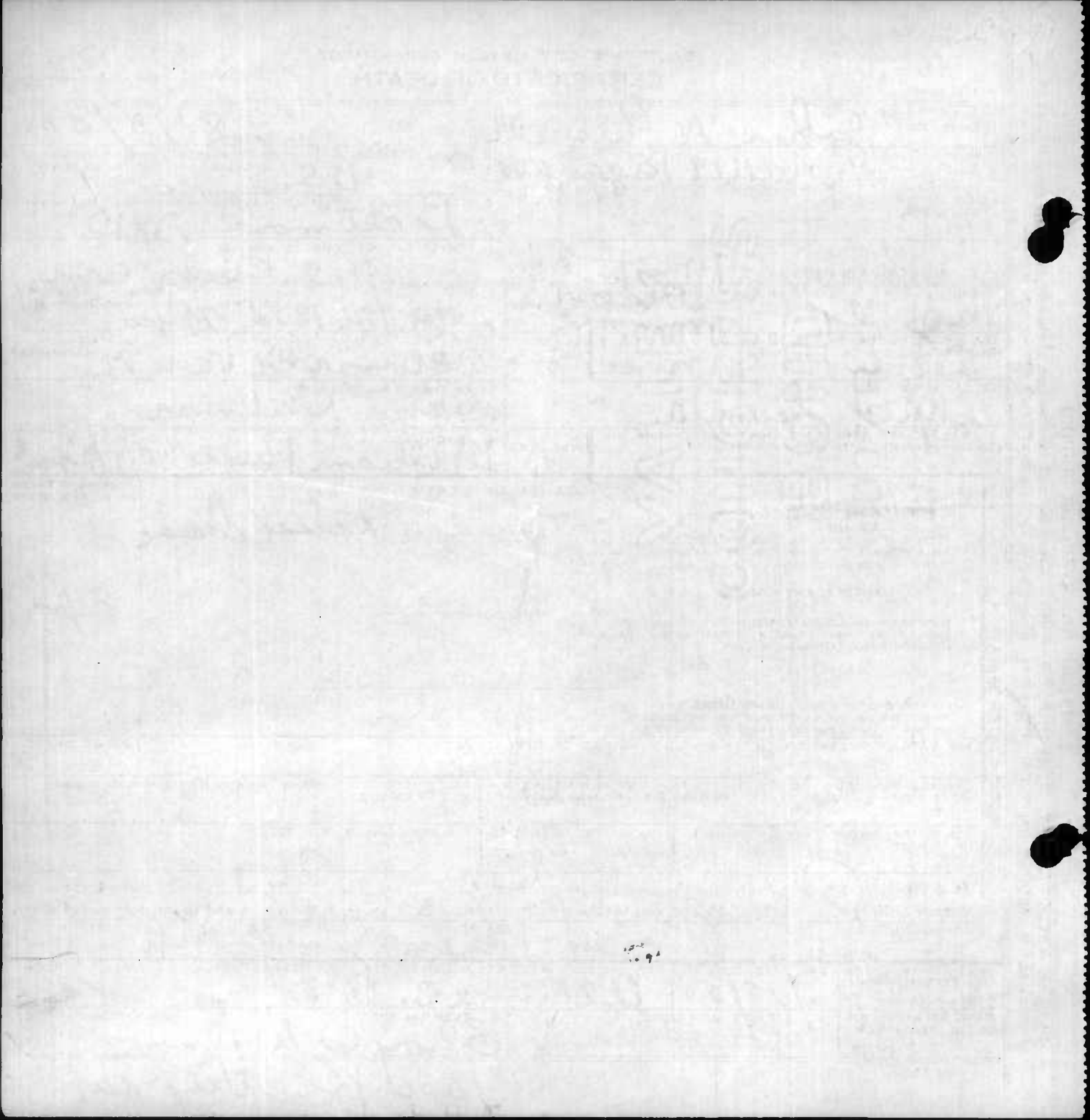
25. FUNERAL DIRECTOR

ADDRESS

AUG 14 1950

VS 150

137a
1000 Brantley Ave



M-416
50 7016BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7016

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES E. MILBOURNE

2. DATE
OF
DEATH

AUG. 10/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

00 1950 W. MULBERRY STREET

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE CITY

20-01

D. STREET ADDRESS (If rural, give location)

1950 W. MULBERRY STREET

c. Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

AUG. 22-1885

9. AGE (In years
last birthday)

64

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Motion-picture Oper.

10B. KIND OF BUSINESS OR
INDUSTRY

Roslyn Movies

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Henry W. Milbourne

14. MOTHER'S MAIDEN NAME

Annie C. Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

215-01-4583

17. INFORMANT

ADDRESS

Marie A. Milbourne..... Same.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

Coronary occlusion, acute

DUE TO

(B)

Arteriosclerosis and hypertensive
cardio-vascular disease.

DUE TO

(C)

with chronic myocarditis.

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 Nov, 1949, to 10 Aug, 1950, that I last saw the
deceased alive on 10 Aug, 1950, and that death occurred at 9:50A. M., from the causes and on the date stated above.

23A. SIGNATURE

Emil H. Henning Jr. M. O.

23B. ADDRESS

601 Winans Way

23C. DATE SIGNED

Aug. 12/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 14/1950

24C. NAME OF CEMETERY OR CREMATORY

London Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

F. B. Wippert & Son

VS 150

3628K

F. B. WIPPERT & SON 1300 EUTAW PL. 17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WIFE

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7017

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*John L. Butler*2. DATE
OF
DEATH

8/11/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Maryland Baltimore*B. FULL NAME OF
HOSPITAL OR
INSTITUTION*Sinai Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Dundalk**6300*

C. Length of stay in Baltimore

2

D. STREET ADDRESS (If rural, give location)

2704 Old North Point Road

5. SEX

M.

6. COLOR OR RACE

*W.*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*M.*

8. DATE OF BIRTH

*June 12, 1898*9. AGE (In years
last birthday)*52*10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Unemployed Helper - RESTAURANT*10B. KIND OF BUSINESS OR
INDUSTRY*RESTAURANT*

11. BIRTHPLACE (State or foreign country)

*Sparrows Point, Md.*12. CITIZEN OF
WHAT COUNTRY?*U.S.A.*

13. FATHER'S NAME

Jerome Butler

14. MOTHER'S MAIDEN NAME

*Gertrude Lettier*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lillia M. Butler, Dundalk 22, Md.

18.

581.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Portal Cirrhosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

arteriosclerotic heart disease

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH*(over)*OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐NOT WHILE ☐

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-9*, 19*50*, to *8-11*, 19*50*, that I last saw the
deceased alive on *8-11*, 19*50*, and that death occurred at *3 P.* m., from the causes and on the date stated above.

23A. SIGNATURE

Henry C. Stephan

M. D.

23B. ADDRESS

Sinai Hosp.

23C. DATE SIGNED

*8-11-50*24A. BURIAL, CREM-
ATION, REMOVAL (Specify)

24B. DATE

Aug. 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Baltimore Co., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Roland L. Fisher, 2112 Dundalk

AUG 14 1950

VS 150

790 6M

124 B ave

Would you advise, what
in your opinion, would be
the underlying cause, + which may be considered contributory -

A H D vs Portal cirrhosis

"Portal cirrhosis" = underlying cause

See Document File 58-7017

8.24.50

ES

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7018

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Emma High

2. DATE
OF
DEATH

Aug-11-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

416-N-Register st

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

416-N-Register st

C. Length of stay in Baltimore

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years, last birthday)

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Robert Green

14. MOTHER'S MAIDEN NAME

Margaret Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

217-12-9265

17. INFORMANT

ADDRESS

Lawrence T. Boston 416-N-Register st

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ... DUE TO

Cerebral Hemorrhage

4 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ... DUE TO

Left Hemiplegia

2 years

(C) ...

Hypertension

?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Sept 1948, to Aug 11, 1950, that I last saw the deceased alive on Aug 11, 1950, and that death occurred at 9:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Albert R. Lefebvre

M. D.

822 N. Bond St

8/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR

ADDRESS

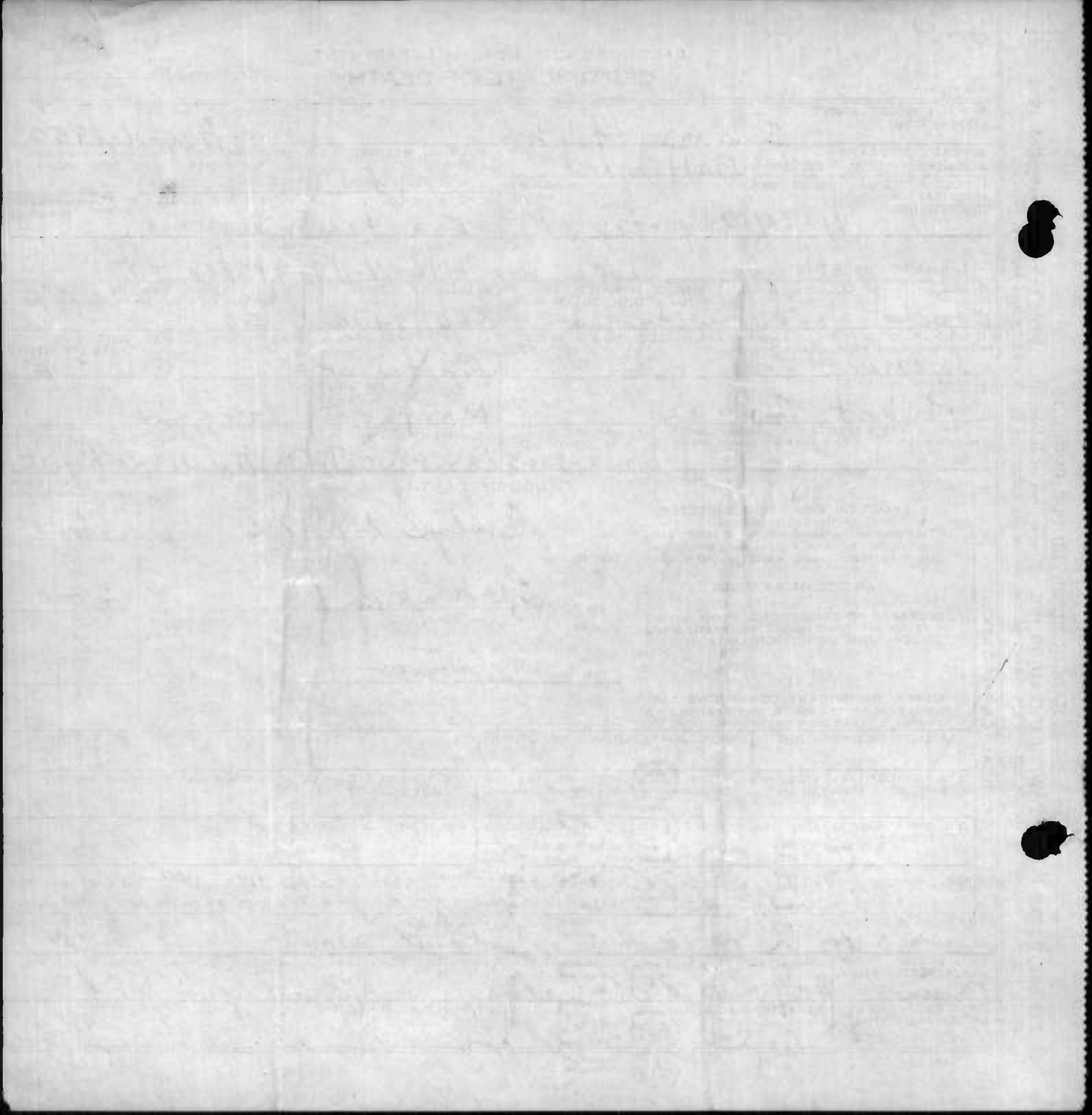
AUG 14 1950

Huntington Williams, M.D. Holland Funeral Home 1631-17th Hill Ave

VS 150

97099

82a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7019
Registered No.

BIRTH NO.

| | | | | | |
|---|------------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) FRANK C. PRESSLEY | | | 2. DATE OF DEATH August 10, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-43 | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 2508 S. Paca Street | | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH July 8, 1911 | 9. AGE (In years last birthday) 39 | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY VENETIAN Blind Co. | 11. BIRTHPLACE (State or foreign country) MONTGOMERY, ALA. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Jacob Pressley | | | 14. MOTHER'S MAIDEN NAME CORA GOLSON | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 257-32-4137 | 17. INFORMANT ADDRESS Mable Pressley - 905 Forrest St. | | |

| | | |
|--|---|----------------------------------|
| 18. E 900.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fractured skull | CAUSE OF DEATH (A) Fractured skull DUE TO | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Bilateral subdural hematoma Intracranial hemorrhage Bronchopneumonia | (B) Bilateral subdural hematoma (C) Bronchopneumonia | |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|--|
| 19A. DATE OF OPERATION August 8, 1950 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2508 S. Paca Street |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 8, 1950 7.45pm. | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR? Fell down cellar steps while intoxicated |
| 22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | |

| | | |
|---|---|--|
| 23A. SIGNATURE Stanley H. Deanecker | 23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR..... | 23C. DATE SIGNED August 11, 1950 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-14-50 | 24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery Baltimore, Maryland |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | 25. FUNERAL DIRECTOR Chas. R. Law - 802 Madison Ave | ADDRESS |
| DATE RECEIVED BY LOCAL REGISTRAR Aug 15 1950 | REGISTRAR'S SIGNATURE William Williams, M.D. | |

VS 151

N-803.0

97033

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 7020**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William A. Becker

2. DATE
OF
DEATH

Aug 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1621 Belt St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1621 Belt St.

c. Length of stay in Baltimore

55 yrs

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Feb. 20, 1876

9. AGE (In years last birthday)

74

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Freight Conductor Retired

10B. KIND OF BUSINESS OR INDUSTRY

B & O R.R.

11. BIRTHPLACE (State or foreign country)

Adams Co., Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry A. Becker

14. MOTHER'S MAIDEN NAME

Mary Starner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Grace L. Becker, 1621 Belt St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Myocardial insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio sclerosis, & Hypertension

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 2, 1950**, to **Aug 10, 1950**, that I last saw the deceased alive on **8/9, 1950** and that death occurred at **1030 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

John C. Scheurich

23B. ADDRESS

1337 S. Charles St

23C. DATE SIGNED

8/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

8/14/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State)

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 14 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tickner & Son Baltimore

ADDRESS

VS 150

203 50

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

WILLIAM A. HARRIS

THE STATE

US CIVIL

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WILLIAM A. HARRIS

THE STATE

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1907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY L. SMITH

2. DATE
OF
DEATH

8/11/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1908 Perlman Place

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1908 Perlman Place

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 28, 1876

9. AGE (In years last birthday)

74

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Evelyn Scocos 1908 Perlman Place

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Gangrene left leg

ANTECEDENT CAUSES

(B) DUE TO

Embolus

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) DUE TO

Cardiac Hypertensive Disease 2 years

7 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 1, 1950 to August 11, 1950, that I last saw the deceased alive on Aug. 11, 1950, and that death occurred at 11:45 P.M.; from the causes and on the date stated above.

23A. SIGNATURE

Albert Eisenberg

M. D.

23B. ADDRESS

7025 E. North Ave.

23C. DATE SIGNED

Aug 12, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/14/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm J. Tschner & Sons, Inc. Balto. Md.

VS 150

931

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 7022**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PERCY

JOHNSON

2. DATE OF DEATH **August 7, 1950**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
530 W. Hoffman St.

C. Length of stay in Baltimore

13 Yrs.
Mos.
Days

5. SEX

Male Colored

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

?? / 9 2 2

9. AGE (In years last birthday)

28

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

Lunch Room

11. BIRTHPLACE (State or foreign country)

Rockingham N. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Elbert Johnson

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give year or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

18. **023X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Syphilitic heart disease**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒, **accident** ☐, **suicide** ☐, **homicide** ☐, **undetermined** ☐.

23A. SIGNATURE

Stanley H. Dunder M.D.

23B. CHIEF MEDICAL EXAMINER.....☐

ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

August 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/14/50

24C. NAME OF CEMETERY OR CREMATORY

Arbutus

24D. LOCATION (City, town, or county)

30E

DATE RECEIVED BY LOCAL REGISTRAR

AUG 14 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

A. Halstead - 918 -

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

CENTRAL BANK OF THE UNITED STATES
WASHINGTON, D. C.
CERTIFICATE OF DEPOSIT

1218

DATE OF DEPOSIT

AMOUNT

TO THE ORDER OF

PAY TO THE ORDER OF

THIS CERTIFICATE IS SUBJECT TO THE

REGULATIONS OF THE BOARD OF

RESERVE BANKS

AND THE FEDERAL RESERVE ACT

AND THE ACT OF MARCH 3, 1933

AND THE ACT OF JUNE 16, 1936

AND THE ACT OF JULY 26, 1941

AND THE ACT OF SEPTEMBER 21, 1941

AND THE ACT OF DECEMBER 17, 1941

AND THE ACT OF JANUARY 14, 1942

SEC

NO

DATE

TIME

PLACE

BY

FOR

BY

FOR

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

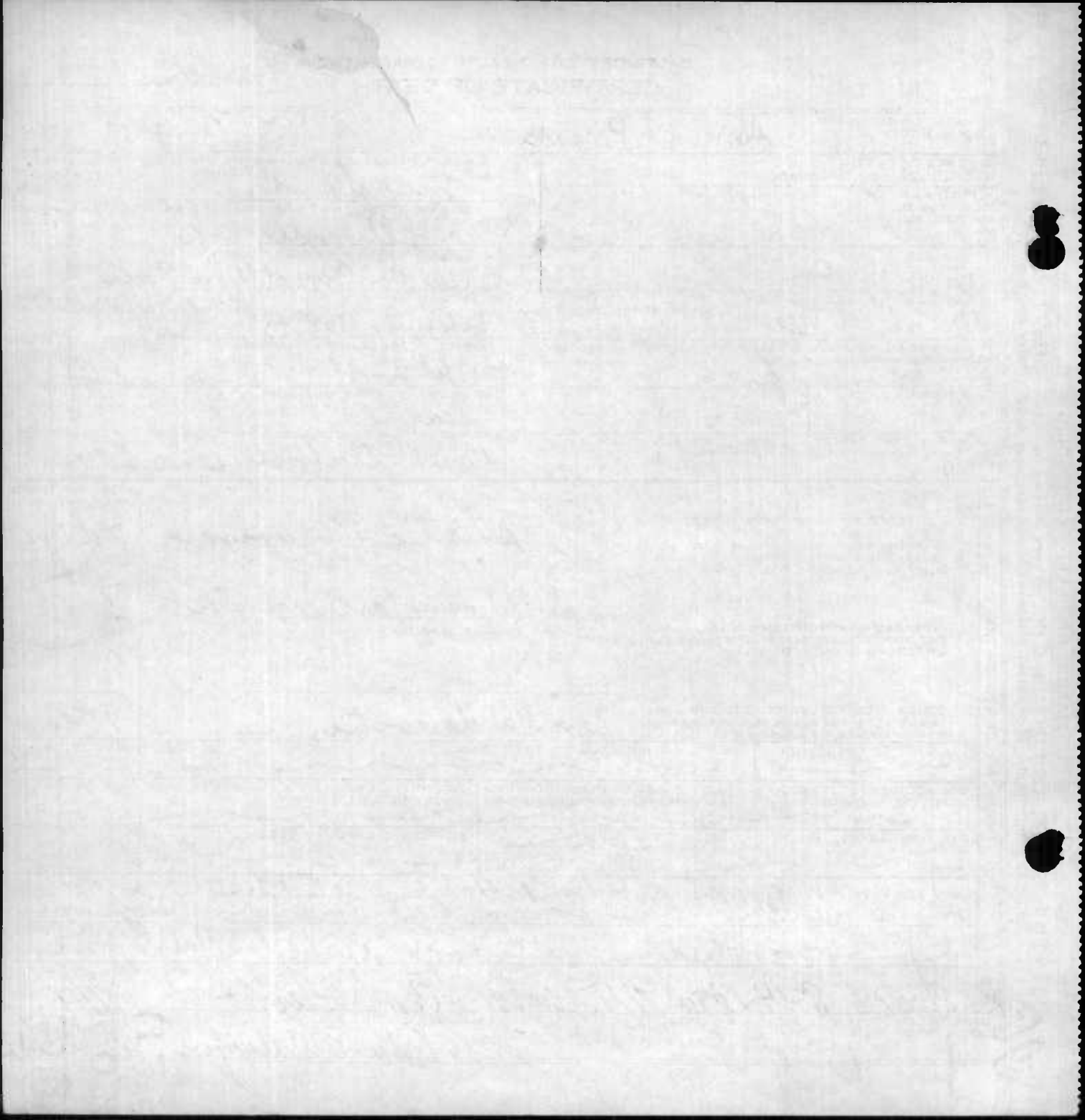
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7023
Registered No.

B-650
50 7023
BIRTH NO.

| | | | |
|---|------------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) Annie Brown. | | 2. DATE OF DEATH Aug. 10, 1950. | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland. B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 80 412 N. Carrollton Ave. | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-02 | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 412 N. Carrollton Ave. | |
| 5. SEX Female | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Sept. 9, 1864 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years: last birthday) 85 |
| 11. BIRTHPLACE (State or foreign country) Wilmington, N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME Sarah ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no. | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Sarah Stafford | | ADDRESS 412 N. Carrollton Ave. | |

| | | |
|--|--|--|
| 18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Static Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 7 days |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive Cardiovascular Disease | | ? |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senile dementia | | 75 days |
| 19A. DATE OF OPERATION 0 | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from 1. 4. 45 , 19__, to 8. 10. 50 , 19__, that I last saw the deceased alive on 8. 9. 50 , and that death occurred at 5:30 P.m. , from the causes and on the date stated above. | | |
| 23A. SIGNATURE C. M. Pair | 23B. ADDRESS 400 N. Carrollton Ave | 23C. DATE SIGNED 8. 11. 50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Funeral | 24B. DATE 8-14-1950 | 24C. NAME OF CEMETERY OR CREMATORY W. T. Jackson Cms |
| 24D. LOCATION (City, town, or county) Balto. | 25. FUNERAL DIRECTOR Mrs. Katie R. Williams | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1950 | | ADDRESS Schroeder |



PLEASE WRITE PRINTED, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7024

BIRTH NO. 50-16024

1. NAME OF DECEASED
(Type or Print)

Daniel Dolan (Daniel Earl Dolan)

2. DATE
OF
DEATH 8-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
Baltimore 15-11

D. STREET ADDRESS (If rural, give location)
3833 Lewin Ave.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 8, 1950

9. AGE (In years
last birthday)

If Under 1 Year
Months Days

If Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Clarence V. Dolan

14. MOTHER'S MAIDEN NAME

Julia I. Billmeyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

C. V. Dolan

3833 Lewin Ave.

18. 578X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Intestinal Perforation

9 days

DUPLICATE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Intestinal obstruction

DUPLICATE

II

(C) Multiple Fractures

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-3-50

19B. MAJOR FINDINGS OF OPERATION

Intestinal Perforation - Cecal

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from 8-3-50 to 8-12-50 that I last saw the
deceased alive on 8-12-50 and that death occurred at 6:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Indira Landon

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8-12-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

Moreland Memorial Ceme.

24D. LOCATION (City, town, or county)

Parkville, Balto. Co., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

W. Vernon Lemmon

ADDRESS

4611 Fk. Hgts. Ave.

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7025

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Margaret A. Gardner,

2. DATE
OF
DEATH

Aug. 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

4642 Park Heights Ave.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

4642 Park Heights Ave.,

C. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 22, 1896

9. AGE (In years last birthday)

53

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Norton,

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Wm. C. Gardner, 4642 Park Heights Ave.

18.

356.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Cerebral Arterio Sclerosis

2

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Amyotrophic Lateral Sclerosis

1 year

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from April 1950 to Aug. 11, 1950 that I last saw the deceased alive on Aug. 10, 1950, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Julius C. Bluch

M. D.

23B. ADDRESS

5356 Reisterstown Road.

23C. DATE SIGNED

8/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

Aug. 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 14 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Vernon Lamm, 4611 Park Heights Ave.

MINISTRE DE LA SANTE
CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Birth | | Date of Death | | Time of Death | |
| Place of Birth | | Place of Death | | Cause of Death | |
| Occupation | | Residence | | Manner of Death | |
| Signature of Physician | | Signature of Coroner | | Signature of Registrar | |
| Date of Signature | | Date of Signature | | Date of Signature | |

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

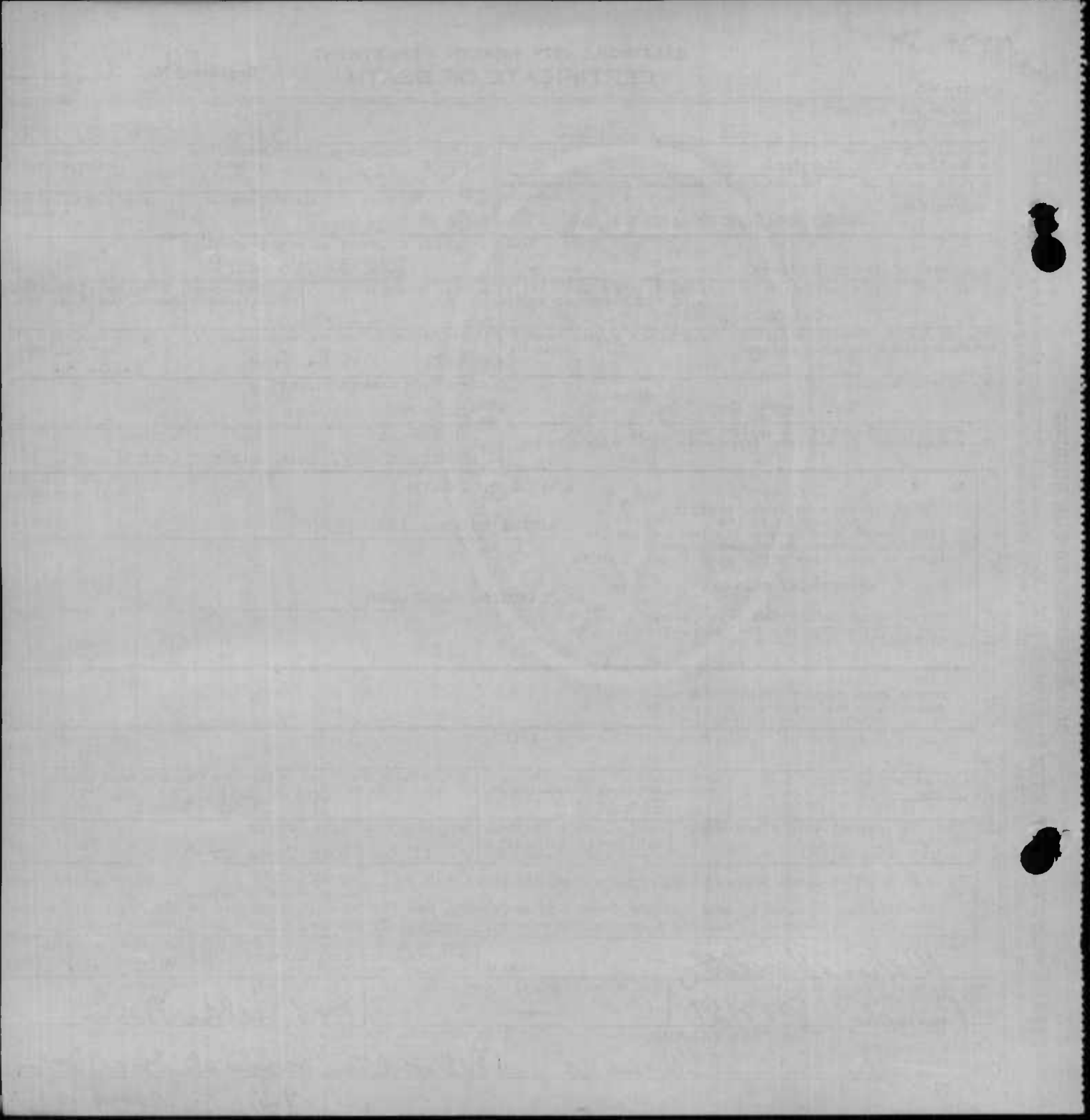
Registered No. 50 7026

BIRTH NO. 000 50 7026

| | | | | | |
|---|------------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) GUY HART | | | 2. DATE OF DEATH August 12, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-01 | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 1602 Booker Court | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 42 | If Under 1 Year Months Days If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Warren Co., N. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Wm. Henry Guy | | | 14. MOTHER'S MAIDEN NAME Lady Van Burgess | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Macklin Guy, 1602 Booker Court | | |

| | | |
|--|--|----------------------------------|
| 18. F 902.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute alcoholism (A) DOES | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Subdural hematoma (B) DOES | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) South Baltimore General Hosp. 1213 Light Street | |
| 21D. TIME (Month) (Day) (Year) (Hour) July 27, 1950 ? m. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell to floor from stool 24/3 | |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | | |
| 23A. SIGNATURE William V. ... | | 23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR..... | | 23C. DATE SIGNED August 14, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/17/50 | | 24C. NAME OF CEMETERY OR CREMATORY Endfield N. C. | |
| DATE RECEIVED BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE Wm. V. ... | | 25. FUNERAL DIRECTOR ADDRESS Metropolitan Funeral Home, Inc. 186a 927 N. Mount St. | |



THEODORE - DOWKAS

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 7027**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Theodore Dowkas*2. DATE
OF
DEATH*9-1-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION*40 St Agnes Hospital*Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution; residence
A. STATE B. COUNTY*Baltimore Md. Baltimore*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

17 Linden Terrace 5300

5. SEX

M

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

B. DATE OF BIRTH

*Oct. - 1876 73*9. AGE (In years
last birthday)11 Under 1 Year 11 Under 24 Hours
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Restaurant Prop.*10B. KIND OF BUSINESS OR
INDUSTRY*RESTAURANT*

11. BIRTHPLACE (State or foreign country)

*Switzerland*12. CITIZEN OF
WHAT COUNTRY?*Switzerland*

13. FATHER'S NAME

James

14. MOTHER'S MAIDEN NAME

*Isabel*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. *422.1*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *SUBDURAL & SUBARACHNOID*
DUE TO *HEMORRHAGE RIGHT*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *ARTERIO-SCLEROTIC CARDIO -*
DUE TO *VASCULAR DISEASE & PULMONARY*
EDEMA
(C) *BRONCHO PNEUMONIA*

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.*UREMIA*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/2*, 19*50*, to *8/12*, 19*50*, that I last saw the
deceased alive on *8/12*, 19*50*, and that death occurred at *1:40* p. m., from the causes and on the date stated above.

23A. SIGNATURE

John V. Shaw M. D.

23B. ADDRESS

St. Agnes Hosp.

23C. DATE SIGNED

*8/14/50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial Aug 14/50**Breck**Orthodox**Balto**Co.*DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lambert's Home 440 E North Ave

1/12

Blackburn Park House

24 April 1891

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

Blackburn Park House

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

11 X 11

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK

EASTON

2. DATE
OF
DEATH

August 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

The Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

434 S. Tucker St

c Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

White

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

m

8. DATE OF BIRTH

July 11, 1888

9. AGE (In years
last birthday)

62

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR
INDUSTRY

Self

11. BIRTH PLACE (State or foreign country)

m g

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Coston

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Grace C Coston

18. 442X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive arteriosclerotic cardiovascular
disease with renal failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Smith

23B. CHIEF MEDICAL EXAMINER..... ☐

23C. DATE SIGNED

M.D. ASSISTANT MEDICAL EXAMINER..... ☒

August 12, 1950

MEDICAL INVESTIGATOR..... ☐24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial Aug 15 Mt Olivet Balto

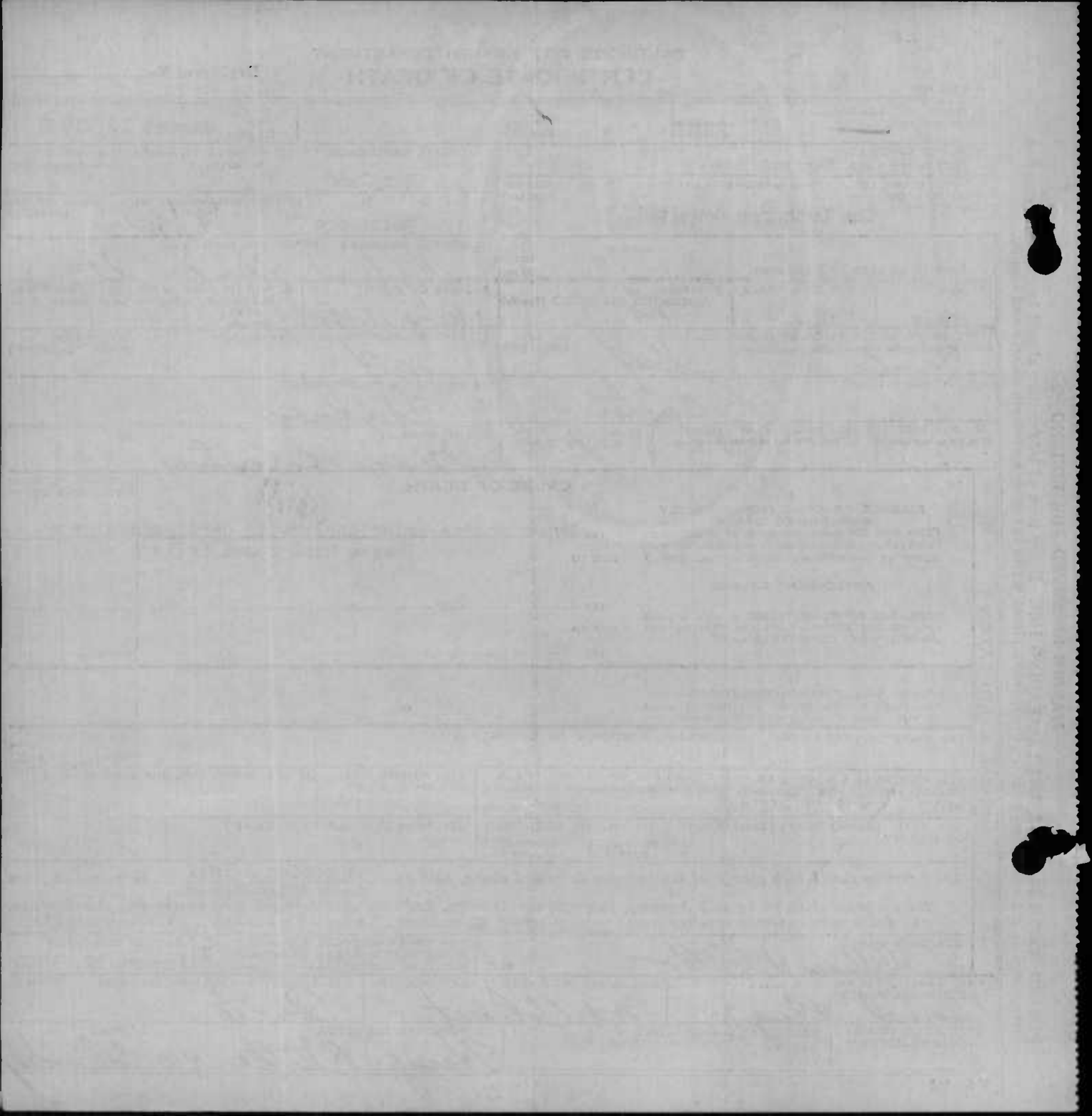
DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Francis A. Kiefer 4101 Columbia



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7029
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) **CHARLES F. MEYER**

2. DATE OF DEATH **8/11/50.**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE **Maryland** B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION **UNION MEMORIAL HOSP.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore - 16-08

c. Length of stay in Baltimore
Yrs. _____
Mos. _____
Days _____

O. STREET ADDRESS (If rural, give location)
3936 Edmondson Ave.

5. SEX **M.**

6. COLOR OR RACE **W.**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married.

8. DATE OF BIRTH **11/7/19**

9. AGE (In years last birthday) **77**
If Under 1 Year Months: Days _____
If Under 24 Hours Hours: Min. _____

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber

10B. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country)
Maryland

12. CITIZEN OF WHAT COUNTRY?
USA.

13. FATHER'S NAME
Charles W. Meyer

14. MOTHER'S MAIDEN NAME
Anna Runge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
216-16-5341

17. INFORMANT ADDRESS
Supson. - Geo. Lather. Same.

18. **493X I**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) **Consecutive Heart Failure**
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Pulmonary Emphysema**
DUE TO

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **Lung Abscesses**
Pneumonia

19A. DATE OF OPERATION **✓**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 10**, 19**50**, to **Aug. 11**, 19**50**; that I last saw the deceased alive on **Aug 11**, 19**50**, and that death occurred at **7:30 A.m.**, from the causes and on the date stated above.

23A. SIGNATURE
James J. Watt

23B. ADDRESS
M.O. Union Memorial Hosp.

23C. DATE SIGNED
8-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
Aug. 14/50

24C. NAME OF CEMETERY OR CREMATORY
Western Edmondson Ave Longwood St. Md

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR
AUG 14 1950

REGISTRAR'S SIGNATURE
Washington Williams, M.D.

25. FUNERAL DIRECTOR
Harry H. Winters

ADDRESS
14101 Edmondson

STATE OF CALIFORNIA
CERTIFICATE OF DEATH



TO BE APPROVED BY CHIEF MEDICAL EXAMINER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7030

BIRTH NO.

50 7030

1. NAME OF DECEASED
(Type or Print)

William E. Cole

2. DATE
OF
DEATH

8-13-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Soo.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION SOUTH BALTO. GEN. HOSP.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto

23-02

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1527 Marshall St

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE MARRIED.

WIDOWED DIVORCED (Specify)

8. DATE OF BIRTH

April 3, 1867

9. AGE (In years last birthday)

83

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

General Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Warsaw Co

11. BIRTHPLACE (State or foreign country)

Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Cole

14. MOTHER'S MAIDEN NAME

Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

Mrs Evelyn Sufix 1527 Marshall St

ADDRESS

18. E 90 r.o.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Rt. Femur.

DUE TO (B) Broncho pneumonia

(B) Prostatic hyperplasia, Cystitis

DUE TO Pyelonephritis.

CERTIFICATION APPROVED BY

(C) Stanley H. Dunbar

M. D.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ARTERIO SCLEROSIS GENERALIZED (SEVERE)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1527 Marshall Street

23/2

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 11, 1950 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell to ground from porch roof

22. I hereby certify that I attended the deceased from 8/11, 1950, to 8/13, 1950, that I last saw the deceased alive on 8/13, 1950, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. Halebian

23B. ADDRESS

South Baltimore General Hospital

23C. DATE SIGNED

8-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial -

24B. DATE

Aug 16, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cem -

24D. LOCATION (City, town, or county) (State)

Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 14 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

G. Howard Evans

ADDRESS

186a

VS 150

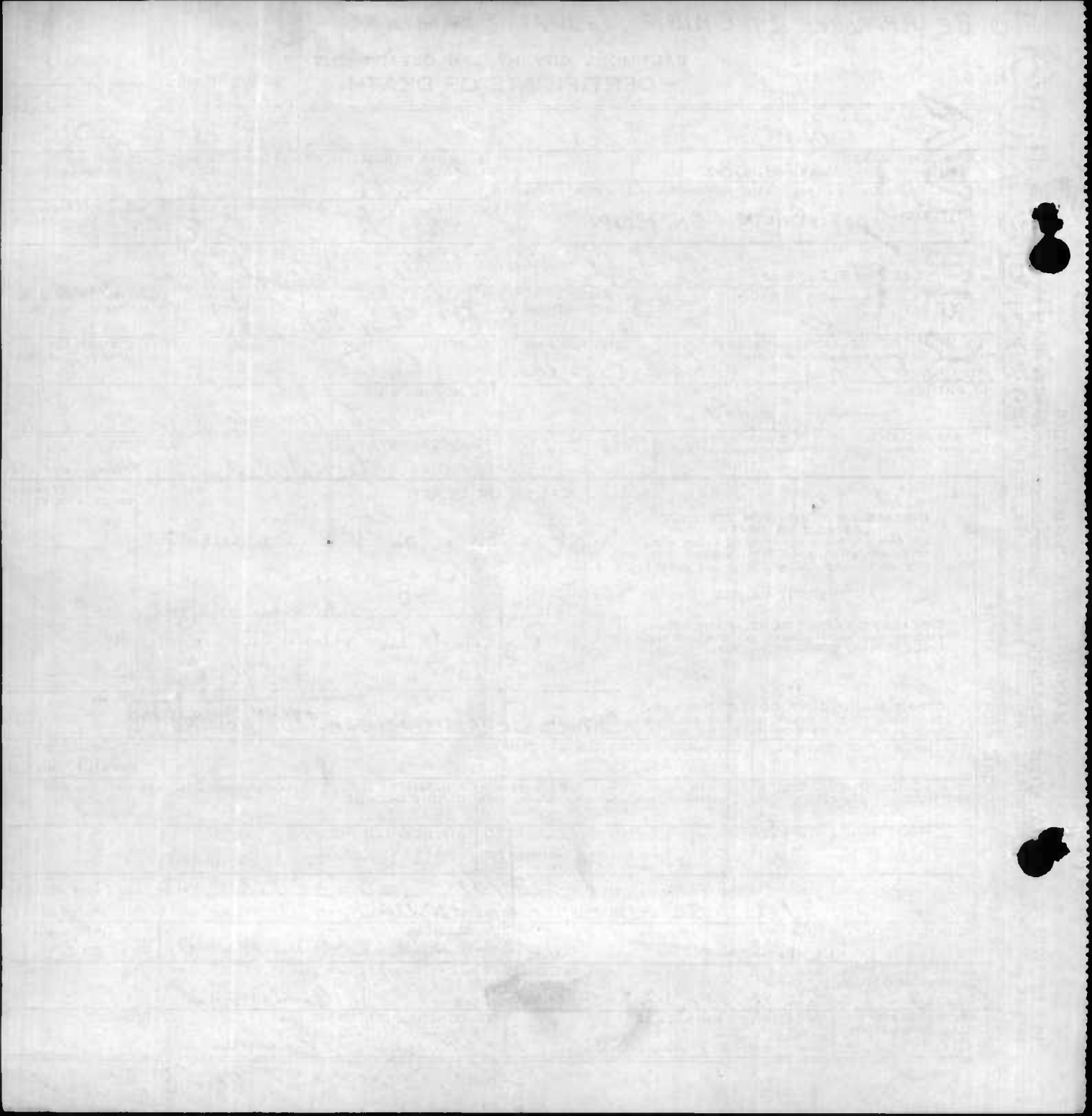
N- 821.0 (H. Halebian)

14005. Charles St Balto 30 Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7031

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles H. Wheatley Jr.

2. DATE
OF
DEATH

Aug 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1278 Battery Ave

4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

00

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

24-03

D. STREET ADDRESS (If rural, give location)

1278 Battery Ave

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 9, 1889

9. AGE (In years
last birthday)

61

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Machine

10B. KIND OF BUSINESS OR
INDUSTRY

Md Drydock

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Charles H. Wheatley Sr.

14. MOTHER'S MAIDEN NAME

Mary A. Burns

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-03-2114

17. INFORMANT

ADDRESS

Rebecca Wheatley 1278 Battery Ave

18.

420.1.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

2 hrs

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 12, 1950 to _____, 19____, that I last saw the
deceased alive on Aug 12, 1950, and that death occurred at 10 P. m., from the causes and on the date stated above.

23A. SIGNATURE

R. S. Wheatley Jr.

M. D.

23B. ADDRESS

1278 Battery Ave

23C. DATE SIGNED

8/14/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 16, 1950

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Cem.

24D. LOCATION (City, town, or county)

Dorsey, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

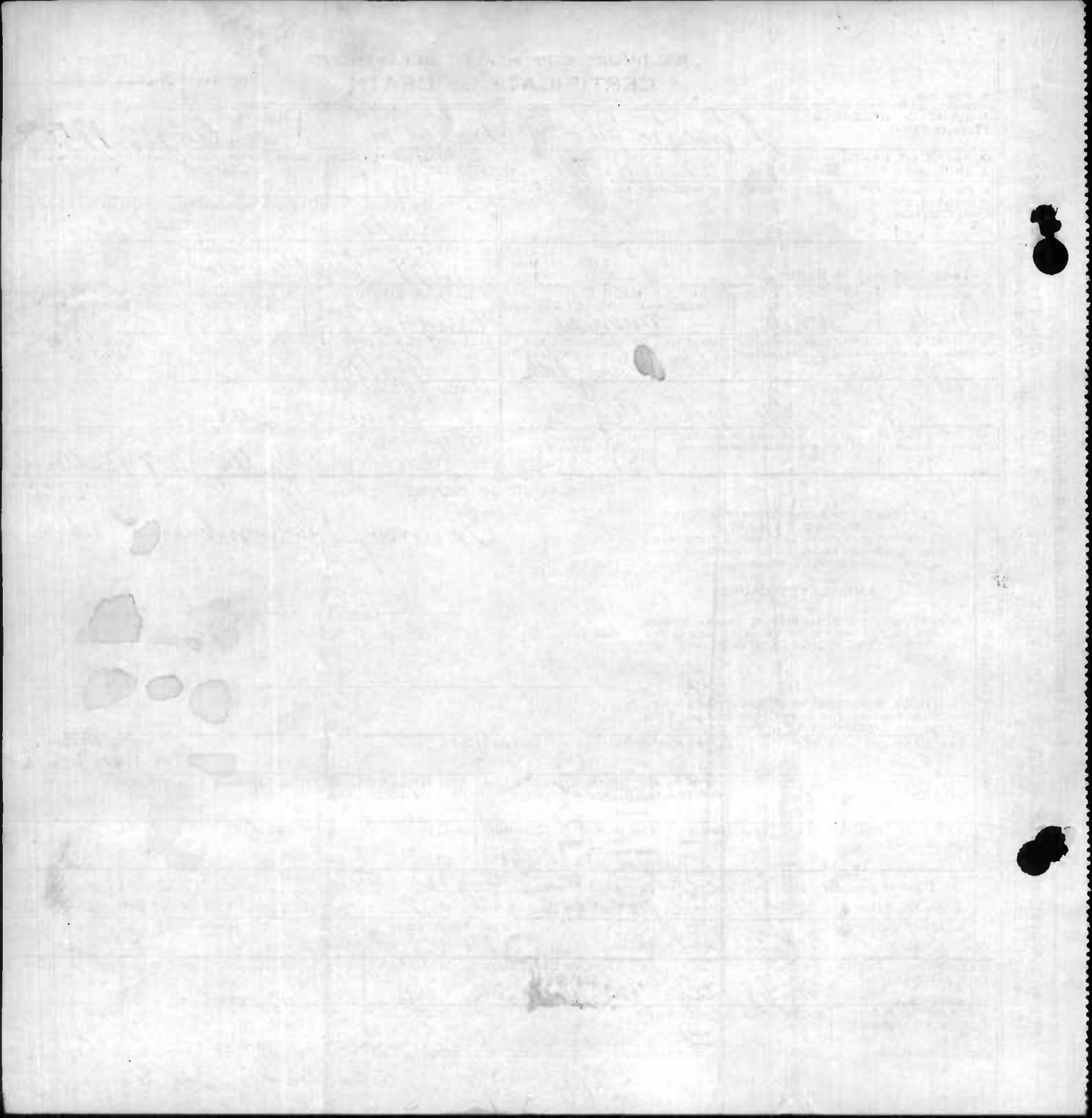
William Williams, M.D.

25. FUNERAL DIRECTOR

P. Howard Evans

ADDRESS

942



B-622
50 7032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7032

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BETTY BERKOWICH

2. DATE
OF
DEATH

8-13-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

before admission)

8. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

3803 Helton Road

C. CITY OR TOWN

(If outside corporate limits, unit, RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3803 Helton Road

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Louis Berkowich - Same

18.

151X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

CARCINOMA of Stomach

INTERVAL BETWEEN ONSET AND DEATH

unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

May 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Stomach

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Sept 13, 1950, that I last saw the deceased alive on Sept 13, 1950, and that death occurred at 11 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Martin L. Sussman M.D.

23B. ADDRESS

11 E. Chase St

23C. DATE SIGNED

8/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

8-15-50

BETH TILGAY

BALTO

MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JACK LEWIS INC - 2100 EUTAW PL

Pingewald
11 1/2 Chase St
Sa 7760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

IOA KLAUVANSKY

2. DATE
OF
DEATH

Aug 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONSibai Hospital
Baltimore, Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Md. 13-02D. STREET ADDRESS (If rural, give location)
2128 Callow Ave

c. Length of stay in Baltimore ?

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (In years last birthday)

89

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Isaiah Long

14. MOTHER'S MAIDEN NAME

Ada

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Will Klue - 1719 Penn Ave

18. E900.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Pulmonary congestion and pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Basilar skull fracture

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CERTIFICATION APPROVED BY

Stanley H. Decker M. D.

M. D. ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

at home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2128 Callow Ave. 13/2

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Aug 11, 1950 m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down steps

22. I hereby certify that I attended the deceased from Aug 12, 1950 to Aug 14, 1950, that I last saw the deceased alive on Aug 14, 1950, and that death occurred at 4:42 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Samuel H. Rulin M. D.

23B. ADDRESS

Sibai Hospital

23C. DATE SIGNED

8/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-15-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Herring Run

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

8-17-50

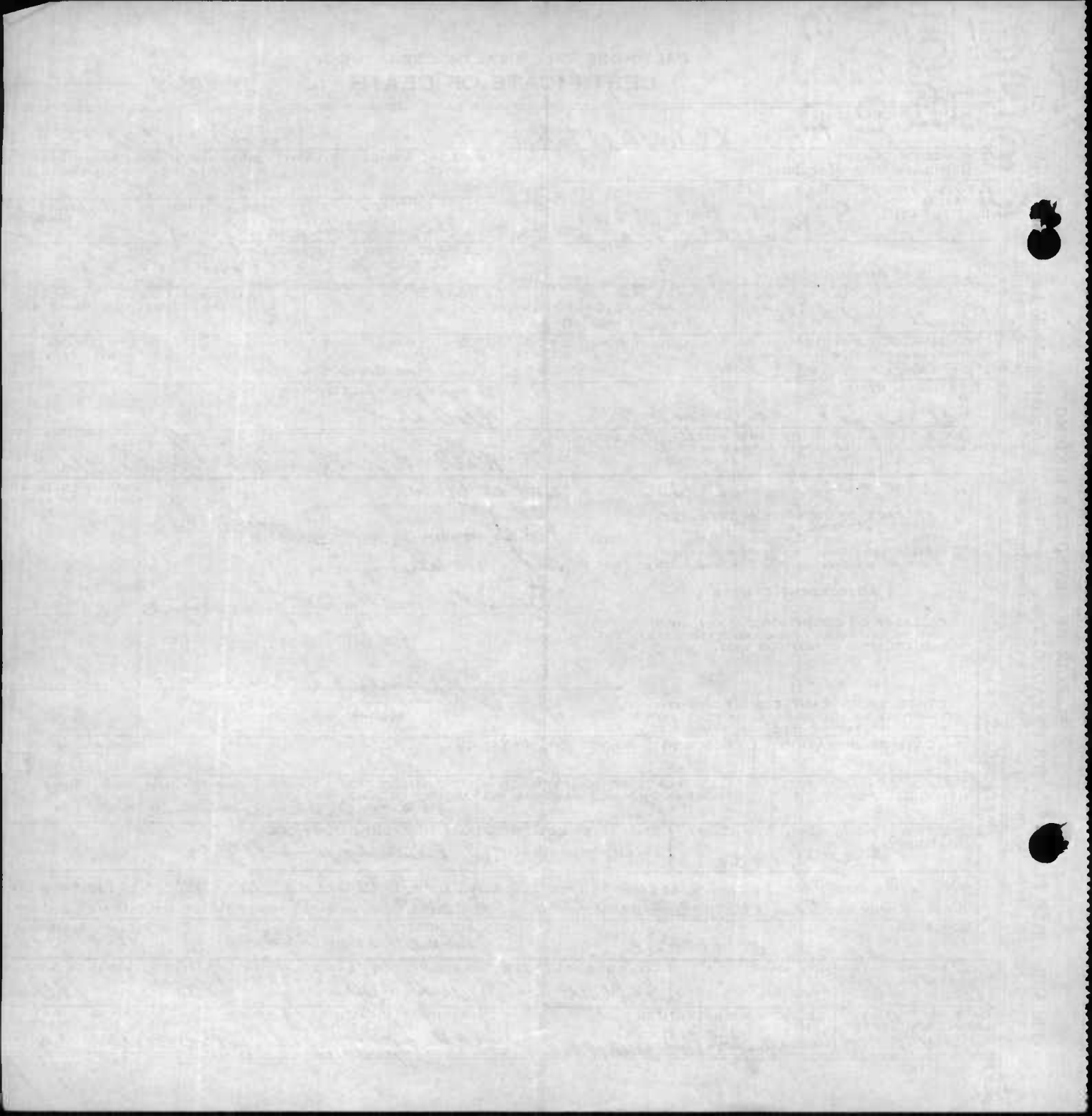
REGISTRAR'S SIGNATURE

T. W. Williams, Jr.

25. FUNERAL DIRECTOR

Jack Lewis Inc 2100 Cutters Pl

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 7034

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lucy Smith

2. DATE

OF DEATH Aug. 13 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION Church Home and Hospital
Broadway and Fairmount Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

Essex

D. STREET ADDRESS (If rural, give location)

357 Townsend Ave.

C. Length of stay in Baltimore

Life

Yrs.

Mos.

Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 28, 1917

9. AGE (In years

32 last birthday)

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter Thomas

14. MOTHER'S MAIDEN NAME

Violet Robbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Husband: Lee Smith

357 Townsend Ave.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

(A) Generalized Peritonitis

13 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Intestinal Obstruction

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Adhesions, Postoperative

19A. DATE OF OPERATION

Aug 7

19B. MAJOR FINDINGS OF OPERATION

Intestinal Obstruction

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 7, 1950, to Aug 13, 1950, that I last saw the deceased alive on Aug 13, 1950, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Kirk Moore, M.D.

23B. ADDRESS

Church Home and Hospital

23C. DATE SIGNED

8-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 16, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Eastern Ave., Essex, Md.

DATE RECEIVED BY LOCAL REGISTRAR

Aug 14 1950

REGISTRAR'S SIGNATURE

T. W. Williams, M.D.

25. FUNERAL DIRECTOR

John G. Connelly

ADDRESS

Essex, Md.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7035

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

CECILIA E. WOFFORD

2. DATE
OF
DEATH

8-10-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

St. Joseph's Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

508 S. Rappolla St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

Dec 23, 1907

9. AGE (In years
last birthday)

42

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House

10B. KIND OF BUSINESS OR
INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Christopher Klemm

14. MOTHER'S MAIDEN NAME

Mary Holston

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lillian Hensler, Victory Villa

18.

416X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Rheumatic heart disease
(inactive)

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/9/50, 19, to 8/10/50, 19, that I last saw the
deceased alive on 8/10/50, 19, and that death occurred at 4:10 P. M., from the causes and on the date stated above.

23A. SIGNATURE

William P. Rodgers, M. D.

23B. ADDRESS

St. Joseph's Hospital

23C. DATE SIGNED

8/10/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 14 - 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Eastern Ave., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 14 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

John J. Connelly

ADDRESS

Casey St., Md.

See Document File 50-7425

9.14.50

20

Inquire if rheumatic
fever was present, active
at time of death?

55-08086

JOSEPH ROBINSON LUBER, SR.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7036

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mr. Joseph Robinson Luber SR.

2. DATE
OF
DEATH

8/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland St. Agnes Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

1301 Summit Ave. Balt.

B. FULL NAME OF HOSPITAL OR INSTITUTION

St. Agnes Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Md. 28

D. STREET ADDRESS (If rural, give location)

Same

5300

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

m.

6. COLOR OR RACE

w.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

m.

8. DATE OF BIRTH

10/11/1889

9. AGE (In years
last birthday)

60

If Under 1 Year
Months: Days:If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Wholesale Feed

10B. KIND OF BUSINESS OR
INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Joseph A. Luber

14. MOTHER'S MAIDEN NAME

Eunice R.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

J. R. Luber, Jr. Landing Road, Catonsville

ADDRESS

18.

420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

(B)

DUE TO

Arteriosclerotic cardiovascular disease
with coronary artery disease

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 8/13, 1950, to 8/13, 1950, that I last saw the
deceased alive on 8/13, 1950, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

William W. Williams

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

8/13/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 16-1950

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park

24D. LOCATION (City, town, or county)

Baltimore Co. Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 14 1950

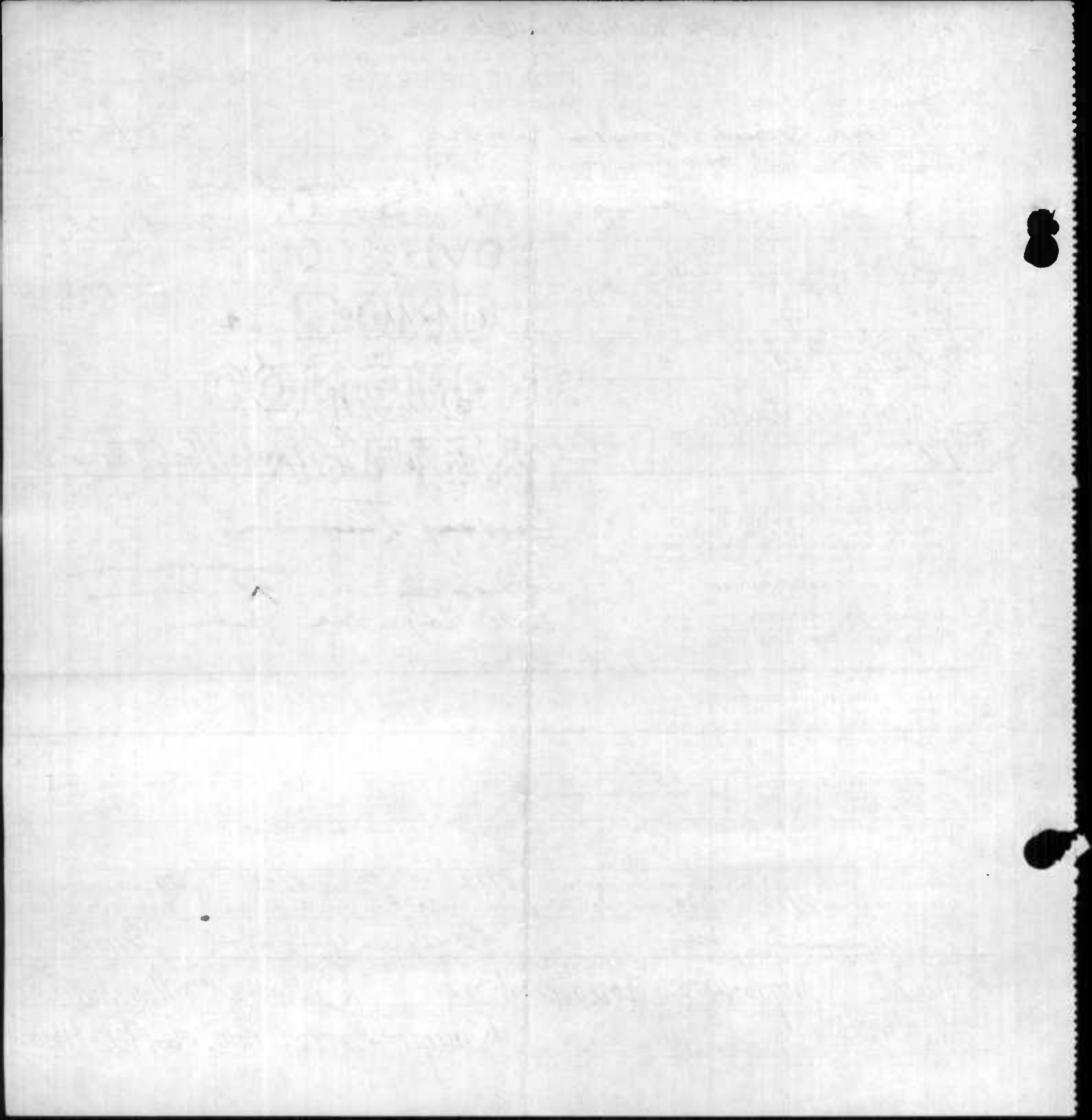
REGISTRAR'S SIGNATURE

William W. Williams, M.D.

25. FUNERAL DIRECTOR

Burgee Funeral Home 3631 Falls Road

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7037
Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|----------------------------------|---|--|-----------------------|--|
| 1. NAME OF DECEASED (Type or Print) NICHOLAS (NICOLA) (DAKCALA) BACCALA | | | 2. DATE OF DEATH August 13, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____ | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-02 | | |
| c. Length of stay in Baltimore 46 Yrs | | | D. STREET ADDRESS (If rural, give location) 306 S. Exeter Street | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH December 9, 1888 | | 9. AGE (In years last birthday) 61 (dmj) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Vasto (Italy) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Saverio Baccala | | | 14. MOTHER'S MAIDEN NAME Maria Antonietta Suriani | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. 214-01-6508 | | 17. INFORMANT ADDRESS | |

18. **E812.01**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Crushed chest**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Second degree burns of face and neck**

(C) **Hypertensive cardiovascular disease**

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
August 11, 1950 5:08 P.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?
Pedestrian struck by truck

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

August 16 1950 Holy Redeemer Cemetery

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)
4430 Belair Road, Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 14 1950

Therese M. Williams

Frank Della Voe 322 S. High St.

V S 151

N-862.2

50424

170c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10
100

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------|--|-----------------------|--|-------------------------------|--|-----------------------------|--|---------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | |
| Place of Birth | | Date of Birth | | Cause of Death | | Manner of Death | | Signature of Physician | |
| Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Police Officer | | Signature of Funeral Home | |
| Signature of Burial Place | | Signature of Cemetery | | Signature of Interment | | Signature of Burial | | Signature of Burial | |

August 10, 1950

100-100000

F 320
50 7038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7038

BIRTH NO.

| | | | |
|--|------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) Henry Fettweis | | 2. DATE OF DEATH Aug. 12, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 5517 Summerfield Rd | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY Baltimore | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) 5517 Summerfield Ave. | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore MD 26-01 | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 5517 Summerfield Rd | |
| 5. SEX M | 6. COLOR OR RACE N | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 17, 1883 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patrol Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 67 |
| 13. FATHER'S NAME Alexander Fettweis | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 12. CITIZEN OF WHAT COUNTRY? ✓ | |
| 16. SOCIAL SECURITY NO. 215-09-6850 | | 17. INFORMANT Mrs. Maria Fettweis | |

| | |
|--|--|
| 18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage DUE TO 6 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive C.V. disease DUE TO 1 day | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Broncho-pneumonia | |

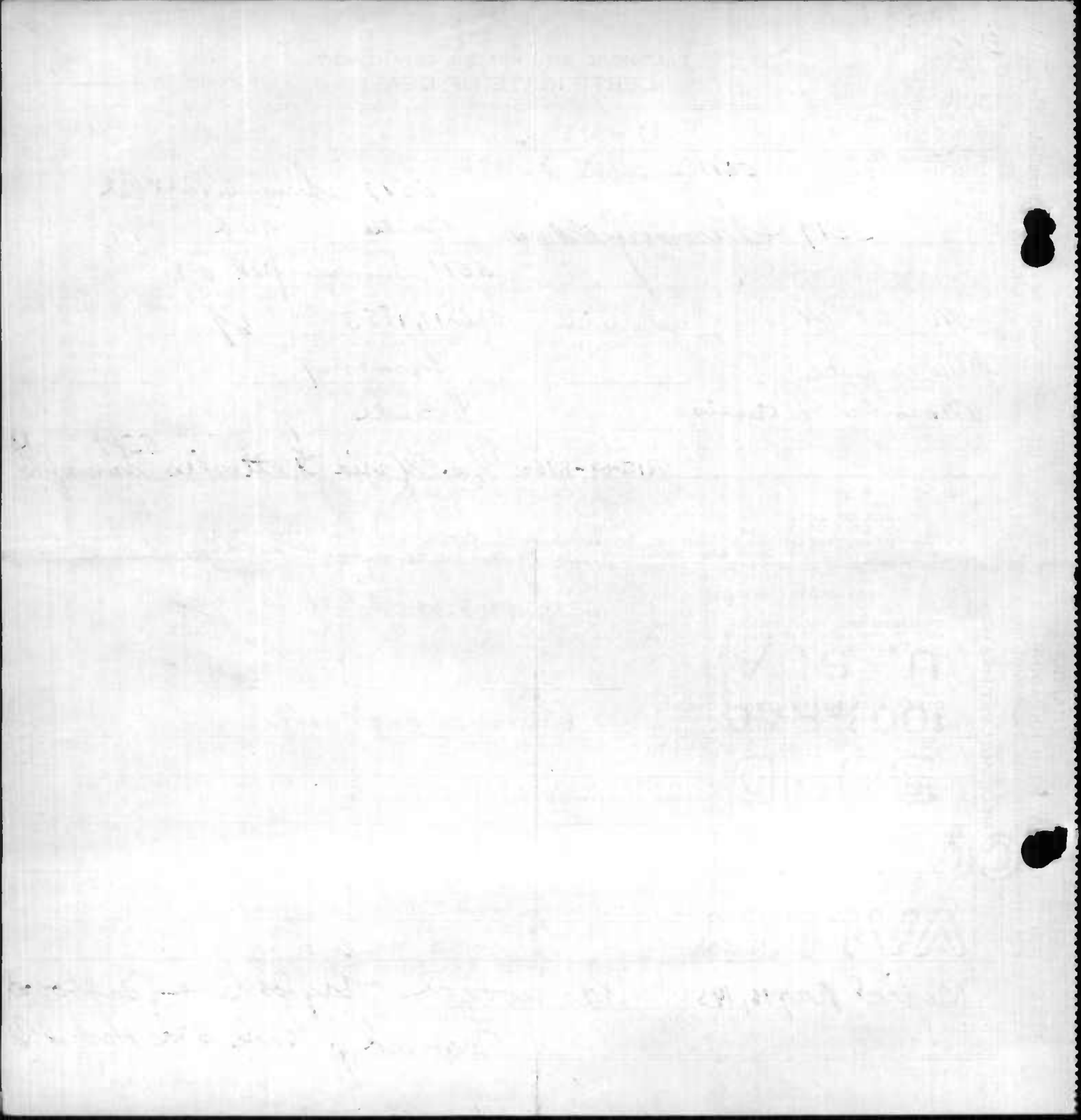
| | | | | | |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug. 4, 1950 to Aug. 12, 1950 that I last saw the deceased alive on Aug. 12, 1950 , and that death occurred at 5 P. m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Donald Jandary | | 23B. ADDRESS 6077 Hayford Rd. | | 23C. DATE SIGNED 8-12-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug 16, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood | |
| 24D. LOCATION (City, town, or county) (State) Playbo Ave Baltimore MD | | 25. FUNERAL DIRECTOR Leonard J. Ruck | | ADDRESS 5305 Hayford Rd | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1950 | | REGISTRAR'S SIGNATURE Wm. Williams, M.D. | | VS 150 | |

51024

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GIZINSKI
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

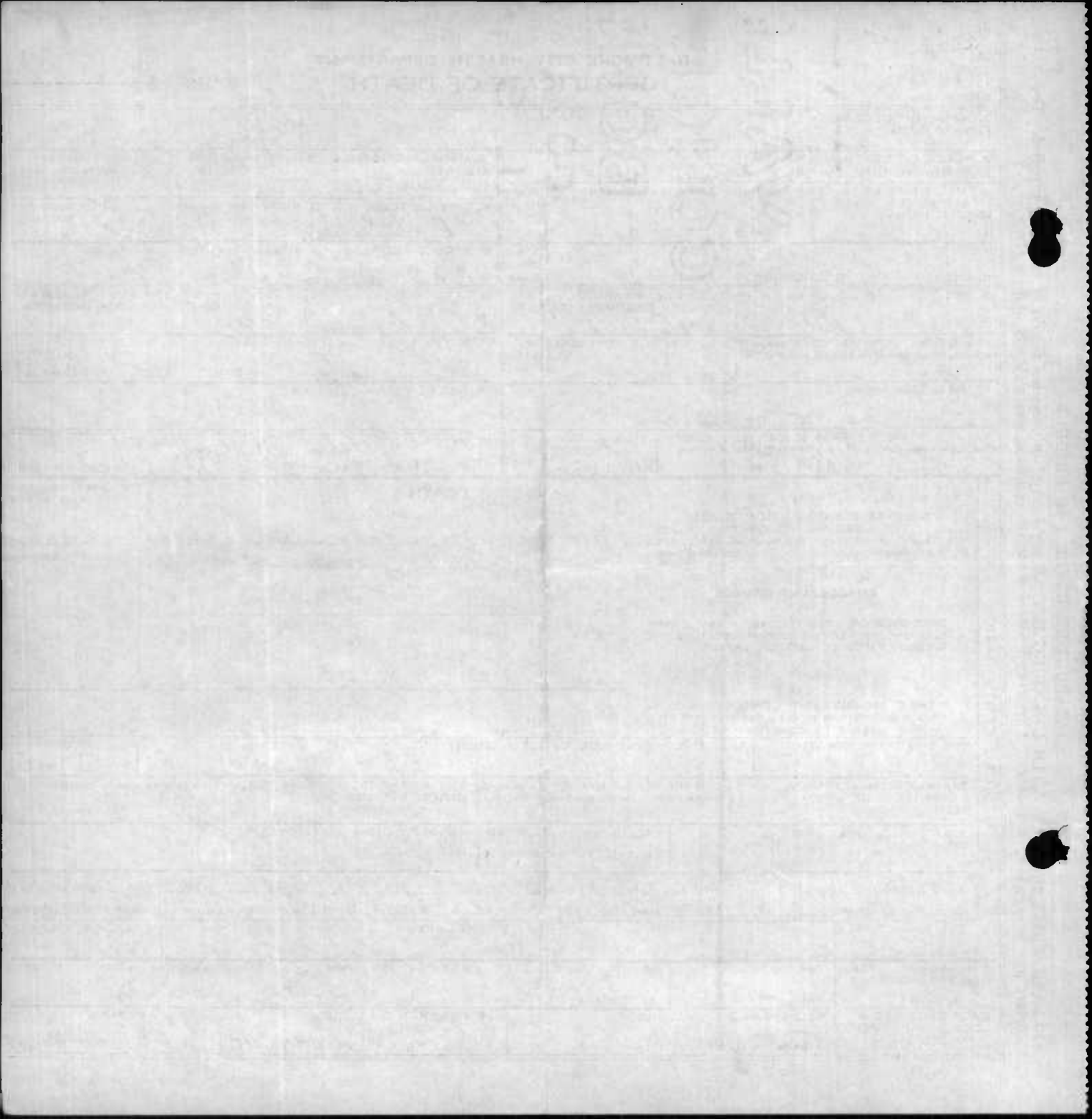
50 7039
Registered No. _____

50 7039
BIRTH NO. _____

| | | | | | |
|--|---------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <u>RODAM GIZINSKI</u> | | | 2. DATE OF DEATH <u>8/12/50</u> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Mercy Hosp.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> | | |
| c. Length of stay in Baltimore <u>40</u> Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) <u>325 S. Chester Street</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>9/14/900</u> | 9. AGE (In years last birthday) <u>49</u> | If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>TAILORING</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>POLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>Yes U.S.A.</u> | | |
| 13. FATHER'S NAME <u>JOSEPH GIZINSKI</u> | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>W.A.D. no 1</u> | | | 16. SOCIAL SECURITY NO. <u>213-05-8337</u> | | |
| 17. INFORMANT <u>Helen Giginas</u> ADDRESS <u>Wife 325 S. Chester St</u> | | | | | |

| | | |
|---|--|----------------------------------|
| 18. <u>541.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH (A) <u>Hemorrhage from duodenal ulcer undetermined</u> DUE TO (B) _____ DUE TO (C) _____ | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|----------------------------------|

| | | | | | |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <u>NONE</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>8/12</u> , 19 <u>50</u> , to <u>8/12</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>8/12</u> , 19 <u>50</u> , and that death occurred at <u>2:25</u> p.m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>Charles R. Ireland</u> | | 23B. ADDRESS <u>Mercy Hospital</u> | | 23C. DATE SIGNED <u>8/12/50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Aug-17/50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Balto. County</u> | | | | | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 14 1950</u> | | REGISTRAR'S SIGNATURE <u>Thurston Williams, M.D.</u> | | 25. FUNERAL DIRECTOR <u>John M. Debe</u> | |
| | | | | ADDRESS <u>401 S. Chester Street</u> | |



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7040
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MAUDE COOPER

2. DATE OF DEATH

8-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE _____ B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Univ. Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

C. Length of stay in Baltimore

43 yrs.

D. STREET ADDRESS (If rural, give location)

1013 Argyle St.

5. SEX

F

6. COLOR OR RACE

C.

7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

March 7, 1896

9. AGE (In years last birthday)

54

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

British Isles

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Ellen Mollineaux

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Leonard Jones 1013 Argyle St.

18. *331X I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral Vascular Accid. 29 hrs

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-11*, 19*50*, to *8-12*, 19*50*, that I last saw the deceased alive on *8-12*, 19*50*, and that death occurred at *5:30* p. m., from the causes and on the date stated above.

23A. SIGNATURE

Robert K. Jones M. D.

23B. ADDRESS

Univ. Hosp.

23C. DATE SIGNED

8/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 16/50

24C. NAME OF CEMETERY OR CREMATORY

Arbutus M-Park

24D. LOCATION (City, town, or county)

Arbutus Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 14 1950

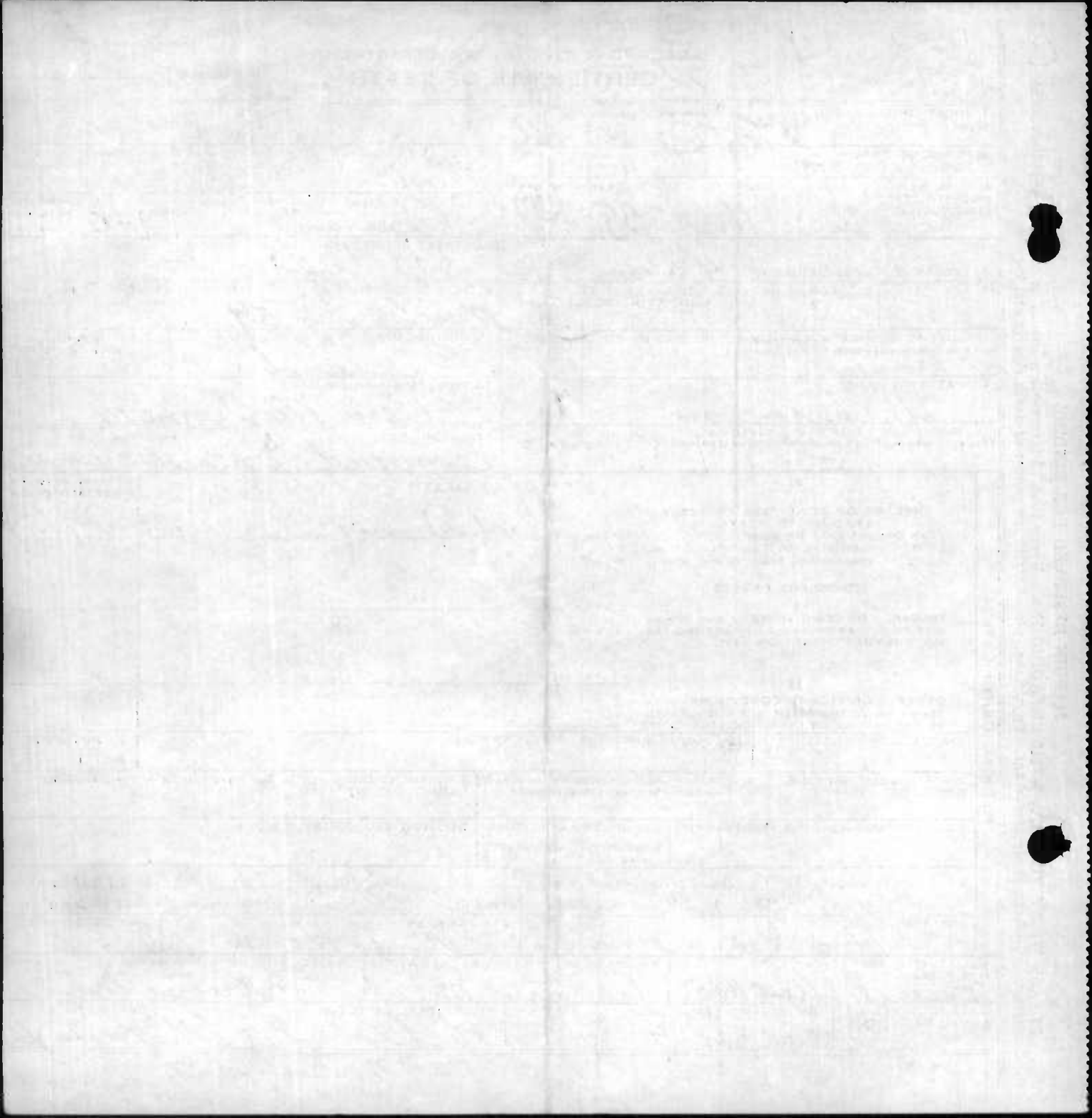
REGISTRAR'S SIGNATURE

William Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

*Mr. Robert G. Elliott & Son
1129 N. Caroline St.*



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7041

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Richard M. Gibson

2. DATE
OF
DEATH

Aug. 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

(If outside corporate limits, write RURAL and give township)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

2609 Smith Ave.

C. CITY OR TOWN

Baltimore 25-42

D. STREET ADDRESS (If rural, give location)

2609 Smith Ave.

C. Length of stay in Baltimore

About 45

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 7, 1880

9. AGE (In years
last birthday)

70

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House Painter

10B. KIND OF BUSINESS OR
INDUSTRY

House Painting

11. BIRTHPLACE (State or foreign country)

Calvert Co., Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard M. Gibson

14. MOTHER'S MAIDEN NAME

Barbara Jane Catterton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-03-1952

17. INFORMANT

Mrs. Annie M. Gibson (wife)

ADDRESS

Same

18.

4 yr. 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

8 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B)

Arteriosclerosis C.V.D.

8 years.

(C)

None

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 1949 to August 1950, that I last saw the
deceased alive on Sept 10, 1950, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Daniel L. Leland

M. D.

23B. ADDRESS

Mrs. L. Leland

23C. DATE SIGNED

8/14/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug - 17, 1950

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Cem.

24D. LOCATION (City, town, or county) (State)

Dorsey, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 14 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

P. Howard Evans 937

ADDRESS

564 24 1400 S. Charles St. Balto 39, Md.

TO THE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

FROM THE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THAT [Illegible]

AND [Illegible]

AND [Illegible]

AND [Illegible]

AND [Illegible]

AND [Illegible]

AND [Illegible]

AND [Illegible]

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AND [Illegible]

AND [Illegible]

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

50 7042

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Leslie A. Soper

2. DATE
OF
DEATH

Aug 12 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland.

B. COUNTY

Calvert

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City 20-07

D. STREET ADDRESS (If rural, give location)

33 South Culver t.

C. Length of stay in Baltimore

25 years

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 29, 1904

9. AGE (In years last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of working life, even if retired)

Life Insurance Co. Salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Huntingtown, Calvert Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Ernest L. Soper

14. MOTHER'S MAIDEN NAME

Md.

Fannie F. Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-01-8113

17. INFORMANT

Mrs. Lillian Bockmiller

ADDRESS

8819 Pressman St.

18. *E900.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Fracture of Skull with*
DUE TO *Intracranial Hemorrhage*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

33 South Culver Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

July 30, 1950

21E. INJURY OCCURRED

A m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell down cellar steps

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☒.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

M.D. MEDICAL INVESTIGATOR

23C. DATE SIGNED

Aug 13 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-16-1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Balto., Md.

ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

G. Howard Strong 3207 W. North Ave.,

VS 151

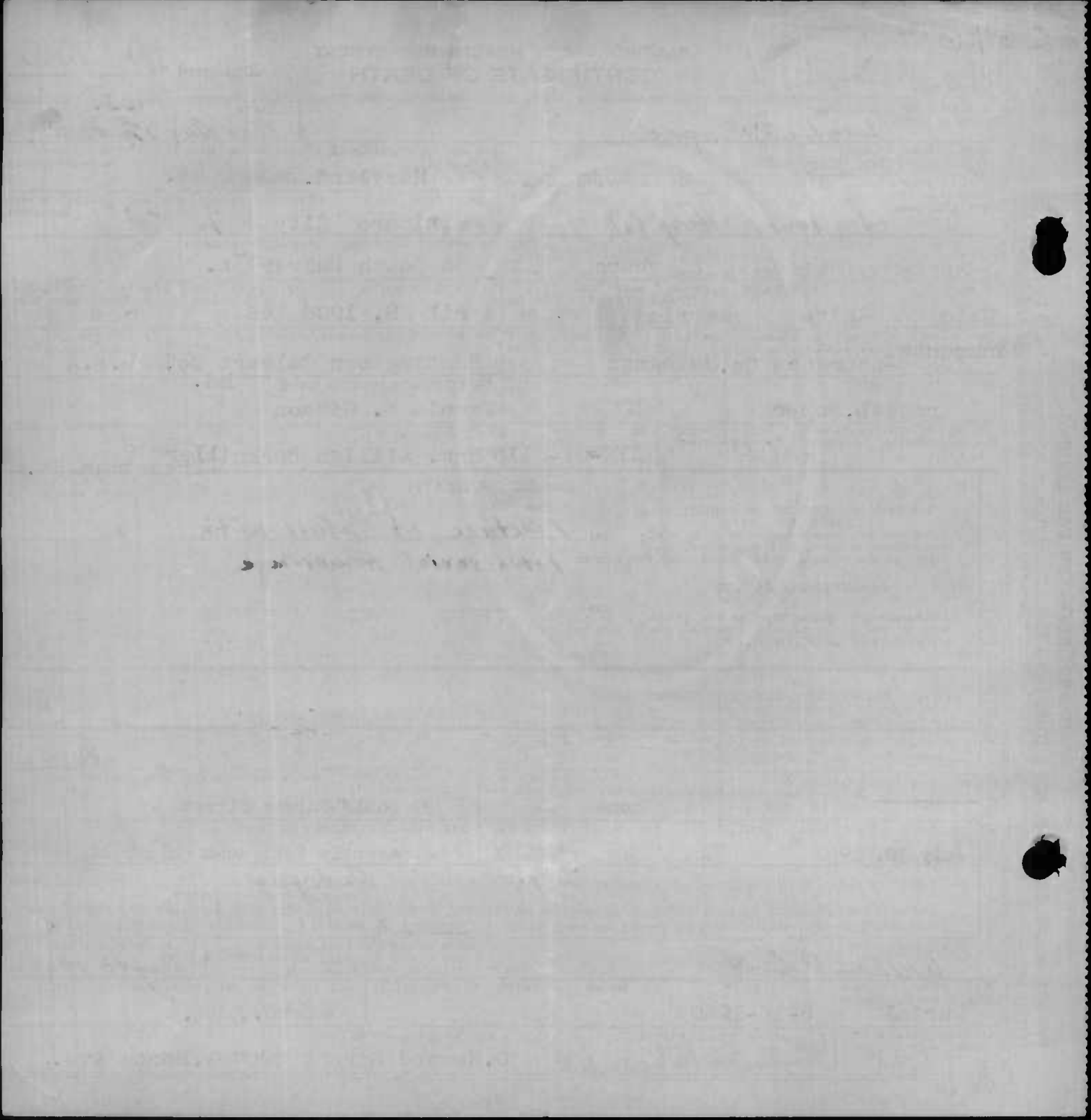
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45073

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7043

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM J. METZEL

2. DATE
OF
DEATH

8/11/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2826 Baker St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2826 Baker St.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 26, 1862

9. AGE (In years
last birthday)

87

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Salesman-Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Gas & Oil

11. BIRTHPLACE (State or foreign country)

Fawn Grove, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jacob Metzels

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Mr. John W. Metzels 2826 Baker St.

18.

177X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Prostate

INTERVAL BETWEEN
ONSET AND DEATH

7 yrs.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

June 16, 1943

19B. MAJOR FINDINGS OF OPERATION

Ca. of Prostate.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

None.

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

None.

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

None.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

None.

22. I hereby certify that I attended the deceased from 3-23, 1937, to 8-11, 1950, that I last saw the deceased alive on 8-1, 1950, and that death occurred at 5:55 p. m., from the causes and on the date stated above.

23A. SIGNATURE

D. D. Caples

M. O.

23B. ADDRESS

Reisterstown, Md.

23C. DATE SIGNED

8-12-50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-15-50

24C. NAME OF CEMETERY OR CREMATORY

Asbury Cem.

24D. LOCATION (City, town, or county)

Reisterstown, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 14 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tickner & Sons, Inc. Balto, Md.

ADDRESS

CERTIFICATE OF DEATH

THE CITY OF BALTIMORE

DATE

YEAR

THE DEPARTMENT OF HEALTH

OFFICE

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature

56 Hospital Disposal 5-256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50 7044

50-16845

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

2. DATE OF DEATH

July 12, 1950

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

710 N. SPRING ST.

8. DATE OF BIRTH

7-12-50

9. AGE (In years last birthday)

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Eleanor Skinner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) ...

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...

DUE TO

(C) ...

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-12-1950 to 7-12-1950 that I last saw the deceased alive on 7-12-1950 and that death occurred at 7:00 P.M. from the causes and on the date stated above.

23A. SIGNATURE

Henry M. Stidel

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

July 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1904

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7045

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

TYLER, EUGENE

EUGENE B. TYLER

2. DATE
OF
DEATH

8-13-50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

BALTIMORE

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

UNIVERSITY

HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

2300

Southern Ave

D. STREET ADDRESS (If rural, give location)

27-03

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

D

8. DATE OF BIRTH

JULY 15 1880

9. AGE (In years
last birthday)

70

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

SELF

10B. KIND OF BUSINESS OR
INDUSTRY

Real Estate

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

US

13. FATHER'S NAME

CORBEN W. TYLER

14. MOTHER'S MARDEN NAME

SUSIA 7.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

-

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

LEVI D. TYLER 2300 SOUTHERN AVE

18.

199.8

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cancer } Site Undetermined

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-31-50, 19, to 8-13, 1950, that I last saw the
deceased alive on 8-3, 1950, and that death occurred at 7:00 m., from the causes and on the date stated above.

23A. SIGNATURE

Walter Glaser M.D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

8/14/50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

AUG 15, 1950

24C. NAME OF CEMETERY OR CREMATORY

MORELAND PARK CEM

24D. LOCATION (City, town, or county)

TAYLOR AVE

(State)

MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

DIPPEL BROS 7110 BELAIR RD.

STATE OF TEXAS

DECEMBER 1930

AMOUNT

THE STATE OF TEXAS

RECEIVED

DATE

NO.

1930

THE STATE OF TEXAS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7046

50 7046
BIRTH NO.

| | | | |
|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <u>MARGARET S. KEYSER</u> | | 2. DATE OF DEATH <u>Aug. 11-1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>510 Rossiter ave</u> | | 4. USUAL RESIDENCE (Where deceased lived, or institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION _____ | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 27-10</u> | |
| c. Length of stay in Baltimore <u>49</u> Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) <u>510 Rossiter ave</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Aug. 3-1901</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 9. AGE (In years last birthday) <u>49</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John B. Keyser</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Peters</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT <u>Mrs. Graham</u> | | ADDRESS <u>510 Rossiter ave</u> | |
| 18. <u>175X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <u>Adeno-Carcinoma</u> DUE TO (B) <u>Gravy (R).</u> DUE TO (C) <u>Myocardial Infarction</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION _____ | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I hereby certify that I attended the deceased from <u>Month 10</u> , 19 <u>50</u> , to <u>Aug 11</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>50</u> , and that death occurred at <u>100</u> m., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE <u>John A. Schumacher</u> | | 23B. ADDRESS <u>1337 S. Charles St.</u> | |
| 23C. DATE SIGNED <u>8/14/50</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>Aug. 15-1950</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Bedau Hill Cem</u> | 24D. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u> |
| DATE RECEIVED BY LOCAL REGISTRAR <u>Aug 14 1950</u> | REGISTRAR'S SIGNATURE <u>Huntington Williams</u> | 25. FUNERAL DIRECTOR <u>Geo. R. Beyer Jr</u> ADDRESS <u>1512 Hollins St</u> | |
| | | <u>Balts. 23 Md.</u> | |

WASHINGTON, D. C. 20540
DEPARTMENT OF STATE



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

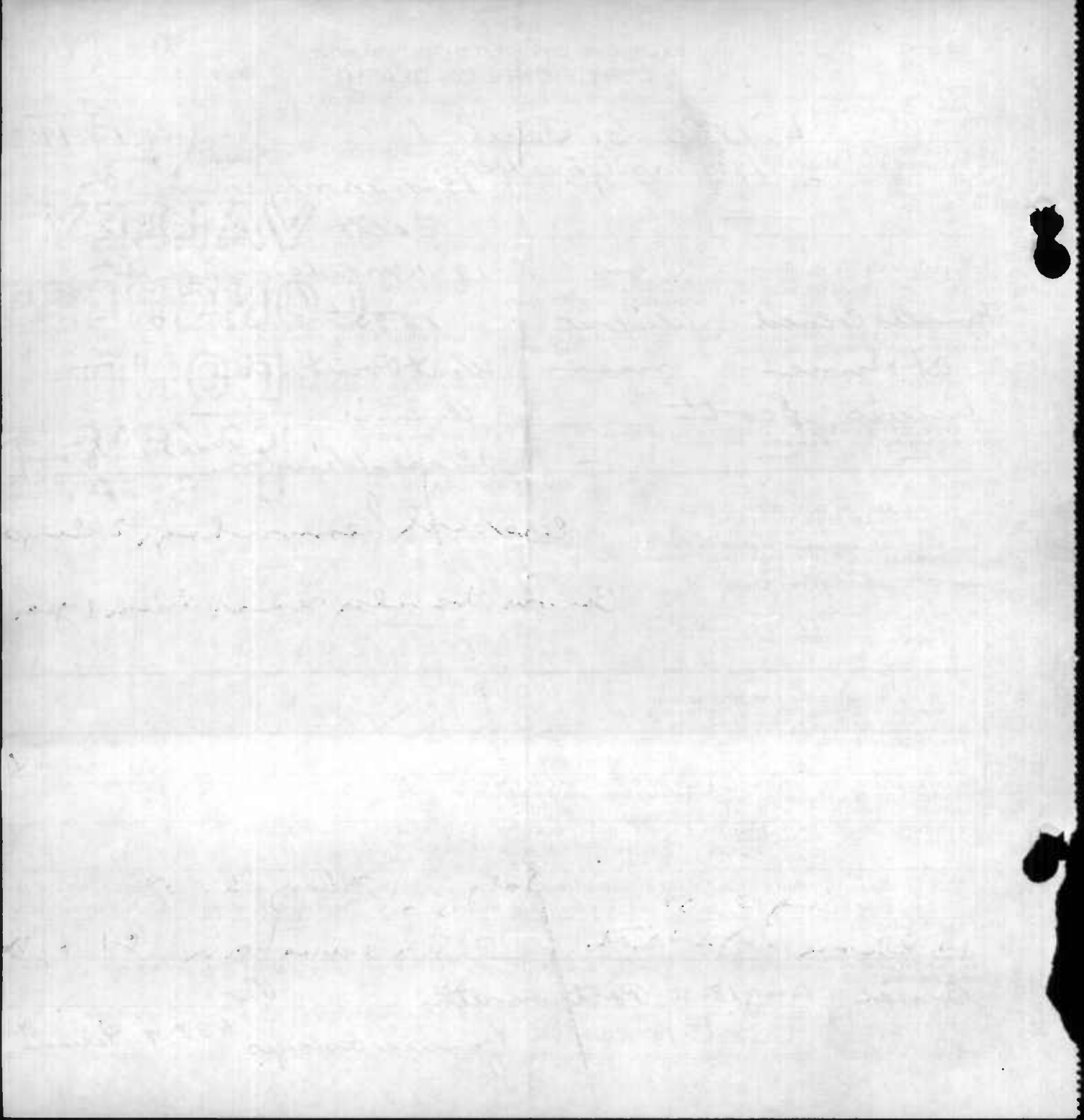
Registered No.

BIRTH NO.

| | | | | | |
|--|--|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Lillie G. Taylor</i> | | | 2. DATE OF DEATH <i>Jan Aug 13-1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>194 W. Montgomery St</i> | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) B. COUNTY <i>St</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Bethesda Md 22-01</i> | | |
| c. Length of stay in Baltimore <i>3 yrs</i> | | | D. STREET ADDRESS (If rural, give location) <i>194 W. Montgomery St</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i> | 8. DATE OF BIRTH <i>1895-</i> | | 9. AGE (In years last birthday) <i>53-</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i> | 11. BIRTHPLACE (State or foreign country) <i>West Point, Va</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>—</i> |
| 13. FATHER'S NAME <i>Lewis Scott</i> | | | 14. MOTHER'S MAIDEN NAME <i>Annie</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | 17. INFORMANT ADDRESS <i>Alfred Winston 194 W. Montgomery St</i> | | |
| 18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral hemorrhage</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Chronic Nephritic renal disease</i> | | | DUE TO <i>1 year</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>July 15, 1950</i> to <i>Aug 13, 1950</i> , that I last saw the deceased alive on <i>Aug 13, 1950</i> and that death occurred at <i>5 A</i> m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>William J. Watts</i> | | 23B. ADDRESS <i>515 E. Lexington</i> | | 23C. DATE SIGNED <i>8/14/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>Aug 18-50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Portsmouth</i> | | 24D. LOCATION (City, town, or county) (State) <i>Va</i> | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 15 1950</i> | REGISTRAR'S SIGNATURE <i>Winston Williams, M.D.</i> | | 25. FUNERAL DIRECTOR ADDRESS <i>James A. Stages 638 N. Gilman St</i> | | |

VS 150

131a



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

KUCINSKI
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7048

Registered No. _____

BIRTH NO. _____

| | | | |
|---|----------------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Frank Kucinski</i> | | 2. DATE OF DEATH <i>Aug 13, 1950</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2015 Bank St</i> | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____ | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION _____ | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 2-01</i> | |
| C. Length of stay in Baltimore _____ | | D. STREET ADDRESS (If rural, give location) <i>2015 Bank St.</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>Sept 25, 1882</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY _____ | 9. AGE (In years, last birthday) <i>67</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Poland</i> | | 12. CITIZEN OF WHAT COUNTRY? _____ | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ | | 16. SOCIAL SECURITY NO. _____ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ | | 16. SOCIAL SECURITY NO. _____ | |

| | | |
|---|--|--|
| 18. <i>163X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH (A) <i>Carcinoma - lung</i> DUE TO (B) _____ DUE TO (C) <i>Atherosclerosis - generalized ?</i> | INTERVAL BETWEEN ONSET AND DEATH <i>5 Mo.</i> |
|---|--|--|

| | | |
|---|---|---|
| 19A. DATE OF OPERATION <i>0</i> | 19B. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____ |

22. I hereby certify that I attended the deceased from *Aug 1, 1950*, to *Aug 13, 1950*, that I last saw the deceased alive on *Aug 12, 1950*, and that death occurred at *7:29 a.m.*, from the causes and on the date stated above.

| | | |
|---|--|--|
| 23A. SIGNATURE <i>Louis F. Klewies</i> | 23B. ADDRESS <i>2623 E. Monument St</i> | 23C. DATE SIGNED <i>Aug. 14, 1950</i> |
|---|--|--|

| | | | |
|--|---|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>Aug. 16/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary</i> | 24D. LOCATION (City, town, or county) (State) <i>Baltimore</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 15 1950</i> | REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>Fred W. Ozoguski</i> | |
| ADDRESS _____ | | | |

10/15/54

UNITED STATES DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY

Franklin D. Roosevelt
2015 Farm St.
Chick

2015 Farm St.
Chick

Chick
2015 Farm St.
Chick

Chick
2015 Farm St.
Chick

Chick
2015 Farm St.
Chick

Chick
2015 Farm St.
Chick

Chick
2015 Farm St.
Chick

50 7049

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7049

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Andrew N. White

2. DATE
OF
DEATH

8/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

(before admission)

Md.

Somerset

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR
INSTITUTION location)

709 N. Gilmore St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.

Mos.

Days

5. SEX

M

N

Widowed

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3/22/80

9. AGE (In years,
last birthday)

70

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Farmer

11. BIRTHPLACE (State or foreign country)

Somerset County, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Alfred White

14. MOTHER'S MAIDEN NAME

Christie Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

709 N. Gilmore

17. INFORMANT

ADDRESS

18. 331X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary Edema

4 dy

DUE TO

(B) Cerebro-vascular Accident

1 mo.

DUE TO

(C) Hypertension

19. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1950 to 8/13, 1950 that I last saw the
deceased alive on 8/12, 1950, and that death occurred at 2:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

J. Preston Grant

M. O.

23B. ADDRESS

601 N. Carrollton

23C. DATE SIGNED

8/14/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/15/50

24C. NAME OF CEMETERY OR CREMATORY

Dames & Moore Cemetery, Brookland

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

151950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Oliver O. Wilson

ADDRESS

830

Dames & Moore (Cemetery)

Item 18B Corrected from Duplicate Certificate and
letter sent in by physician. - See document file. - 8/30/50 - M. Amospeck

LC

134031 50 7050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7050

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sarah Leith Grant

2. DATE
OF
DEATH

8-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONBaltimore City Hospitals
4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

3-01

D. STREET ADDRESS (If rural, give location)

1514 E. Pratt Street

c. Length of stay in Baltimore

6 Yr.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 26, 1935

9. AGE (in years
last birthday)

15

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Johnny Grant

14. MOTHER'S MAIDEN NAME

Linda Gatson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Records* Baltimore City Hospitals
4940 Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Pulmonary Tuberculosis

10 Months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., io. or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-7, 1949 to 8-12, 1950, that I last saw the
deceased alive on 8-12, 1950 and that death occurred at 1:00 AM, from the causes and on the date stated above.

23A. SIGNATURE

H. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-14-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/15/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

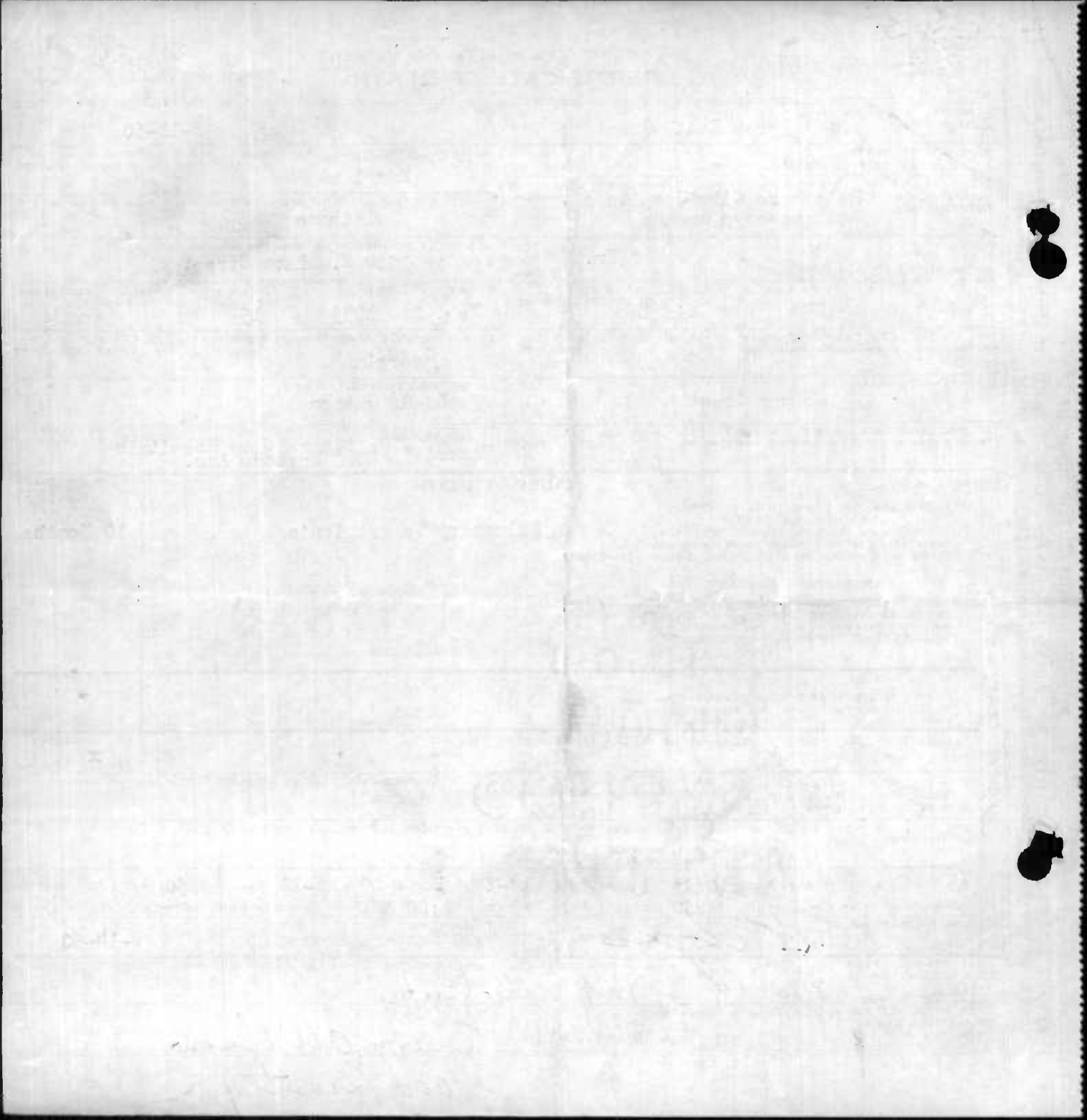
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Clay J. Wilson



50 7051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7051
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES FREDERICK KRAUS

2. DATE
OF
DEATH

Aug. 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 6300 Blenheim Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-12

D. STREET ADDRESS (If rural, give location)

6300 Blenheim Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jul. 14, 1891

9. AGE (In years last birthday)

59

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Proprietor

10B. KIND OF BUSINESS OR INDUSTRY

C. F. Kraus Co.

Wholesale Fish

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Kraus

14. MOTHER'S MAIDEN NAME

Margaret Cloman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Pauline C. Kraus 6300 Blenheim Rd.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

Unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Sept 14, 1949 to August 13, 1950, that I last saw the deceased alive on 8/13, 1950, and that death occurred at 7:50 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/16/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Mausoleum

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 15 1950

Huntington Williams, M.D.

J. J. Tackner & Son, Inc. Balto Md

VS 150

29063

931

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7052

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH FEINSTEIN

2. DATE
OF
DEATH

8/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

SOUTH BALTO. GEN. HOSP.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

24-04

c. Length of stay in Baltimore

9 Yrs.

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1516 Webster Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1883

9. AGE (In years
last birthday)

67

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired- Proprietor

10B. KIND OF BUSINESS OR
INDUSTRY

Tailor

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA,

13. FATHER'S NAME

Isaac Feinstein

14. MOTHER'S MAIDEN NAME

Gischel ??

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Gertrude Faber- 3021 Garrison Blvd.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

MYOCARDIAL INFARCTION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

CORONARY ARTERY OCCLUSION

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) CORONARY ARTERY SCLEROSIS

HYPERTENSIVE CARDIO VASCULAR

DISEASE

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/12, 1950, to 8/14, 1950, that I last saw the deceased alive on 8/14, 1950, and that death occurred at 10:25 P. M., from the causes and on the date stated above.

23A. SIGNATURE

William B. Cooper J.

M. D.

23B. ADDRESS

South Balto Gen. Hosp

23C. DATE SIGNED

8/15/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-14-50

24C. NAME OF CEMETERY OR CREMATORY

Greater Balto. Lodge

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 15 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Sol. Levinson & Bros

ADDRESS 26

W. North Ave.

10

THE STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE
JANUARY 10, 1911

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

1910

ALBANY:

1911

PRINTED BY

THE STATE

PRINTING OFFICE

ALBANY

1911

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 7053

BIRTH NO. 50 7053

| | | | | | |
|--|---------------------------|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) HOWARD COMMONS | | | 2. DATE OF DEATH 8/13/50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 133 W. CROSS ST. | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 23-01 | | |
| c. Length of stay in Baltimore Life | | | D. STREET ADDRESS (If rural, give location) 133 W. CROSS ST. | | |
| 5. SEX M | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH NOV. 11, 1884 | | 9. AGE (In years, last birthday) 65 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore | | | 10B. KIND OF BUSINESS OR INDUSTRY Grain Elevator | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md |
| 13. FATHER'S NAME George Commons | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | | 16. SOCIAL SECURITY NO. 217-07-5132 | | |
| 17. INFORMANT Mary Commons (Wife) | | | ADDRESS 133 W. Cross St. | | |

18. 420.1 CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) arterio sclerosis
DUE TO
(C) ...

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | | | | |
|--|--|---|--|--|--|
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>May 10, 1950</u> to <u>Aug 13, 1950</u> , that I last saw the deceased alive on <u>Aug 11, 1950</u> , and that death occurred at <u>12.20 A.</u> from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Dan Trautman M. D. | | 23B. ADDRESS 122 W. See | | 23C. DATE SIGNED 8/15/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/17/50 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem'l Pk. | |
| 24D. LOCATION (City, town, or county) Balto. County, Md. | | 24E. LOCATION (State) Md. | | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1950 | | REGISTRAR'S SIGNATURE William H. Williams, M.D. | | 25. FUNERAL DIRECTOR Charles W. W. See ADDRESS 512 N. Carrollton Av. | |

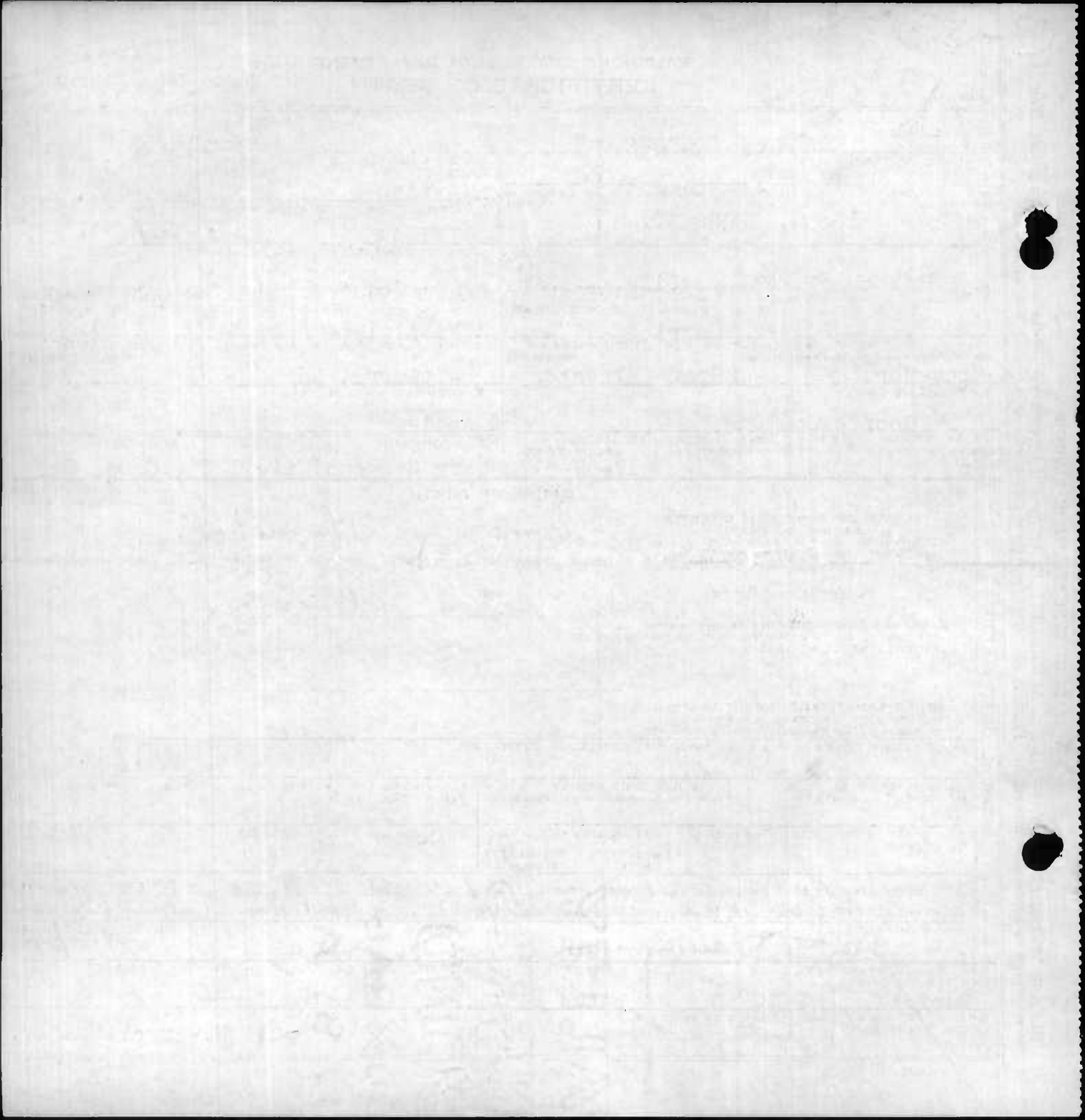
VS 150

94053

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7054

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Stanich.

2. DATE
OF
DEATH

AUG 13 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 1-02

D. STREET ADDRESS (If rural, give location)

640 S. Ellwood Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

8-6-75

9. AGE (in years
last birthday)

75

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Stone Mason

10B. KIND OF BUSINESS OR
INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

Austria

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHN HOPKINS HOSPITAL

ADDRESS

18. 151X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of stomach

6 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Malnutrition, Anemia

19A. DATE OF OPERATION

10 Aug 50

19B. MAJOR FINDINGS OF OPERATION

Bleeding carcinomatous ulcer.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., to or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-6-1950 to 8-13-1950, that I last saw the
deceased alive on 8-13-1950, and that death occurred at 5:00 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Henry T. Bahner

M. D.

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

13 Aug 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8-16-50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Lilly + Ziller - 403 S. Wolfe St.

ADDRESS

AUG 15 1950

VS 150

46 B

St. Louis, Mo. 1880

My dear Mr. [Name]

I have just received your letter of the 10th inst.

and am glad to hear from you.

I am well and hope this finds you the same.

I have not much news to write at present.

I am, however, very busy with my work.

I will write again when I have more news.

I am, dear Mr. [Name], very respectfully,

Your obedient servant,

[Signature]

[Address]

[City, State]

[Post Office]

[Country]

[Date]

[Time]

[Weather]

[Temperature]

[Humidity]

[Wind]

[Clouds]

M-260

50 7055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7055

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)James M^c Guire2. DATE
OF
DEATH

Aug 15, 1950

3. PLACE OF DEATH:

A. Baltimore City Maryland 4706 Roland Ave -

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

27-14

D. STREET ADDRESS (If rural, give location)

4706 Roland Ave

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

?

8. DATE OF BIRTH

Jan 1, 1870

9. AGE (In years
last birthday)

80

10. Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Auditor.

10B. KIND OF BUSINESS OR
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Texas.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Unknown.

14. MOTHER'S MAIDEN NAME

Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

ADDRESS

Miss Anne Martin - 4706 Roland Ave

18. DOX

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pulmonary tuberculosis

INTERVAL BETWEEN
ONSET AND DEATH

6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) ...

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 8, 1950, to Aug 15, 1950, that I last saw the
deceased alive on Aug 15, 1950, and that death occurred at 9:00 m., from the causes and on the date stated above.

23A. SIGNATURE

William G. Helfrich M. D.

23B. ADDRESS

5006 Roland Ave -

23C. DATE SIGNED

Aug 15-1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Aug 16/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Old Frederick Rd. Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Austin E. Donovan - 318 Roland Ave

AUG 15 1950

VS 150

1313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

100-444444

BOND

CONFIDENTIAL

WATKINS

1-1

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 7056**

BIRTH NO.

 1. NAME OF DECEASED
(Type or Print)

Barbara Schneider

 2. DATE
OF
DEATH

August 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Shriner Convalescing Home

 B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

 Shriner Convalescing Home
Hilton & Liberty Hys Ave.,

 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

441 N. Lakewood Ave

 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Md.

 D. STREET ADDRESS (If rural, give location)
441 N. Lakewood Ave.,

c. Length of stay in Baltimore

life

5. SEX

male FE

6. COLOR OR RACE

white

 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
widow

8. DATE OF BIRTH

Sept 29, 1866

9. AGE (In years last birthday)

83

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife at home

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Peter Schonet

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

 16. SOCIAL SECURITY NO.
none

17. INFORMANT

ADDRESS

Edward Peter Schneider (son) 441 N. Lakewood

18. 260X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

 Cerebral Hemorrhage -
arterial Hypertension

(B)

DUE TO

arterio-sclerosis

(C)

cerebral Metastasis

aug 13/50

10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

 YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

 21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 31, 1950, to Aug 13, 1950, that I last saw the deceased alive on Aug 12, 1950, and that death occurred at 1:30 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

 24A. BURIAL, CREMATION, REMOVAL (Specify)
burial

24B. DATE

Aug 15, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cem.

24D. LOCATION (City, town, or county)

Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 15 1950

Huntington Williams, M.D.

 Schimunek Funeral Home Inc
2801 05 05 E. Madison St.

DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

WOMAN'S NAME

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7057
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHRISTIAN BOLLACK

2. DATE
OF
DEATH

Aug. 11, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2419 Fleet Street

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

June 16, 1870

9. AGE (In years
last birthday)

80

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

produce dealer

10B. KIND OF BUSINESS OR
INDUSTRY

self emp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Bollack

14. MOTHER'S MAIDEN NAME

Catherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If Yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT
Mrs. Catherine Borleis
644 S. Kenwood Ave.

ADDRESS

18.

331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)
DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

Senile Arteriosclerosis, Generalized 3 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April**, 19**49**, to **August 12**, 19**50**, that I last saw the
deceased alive on **August 11**, 19**50**, and that death occurred at **3:40 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE

Clarence W. LeDoux

M. D.

23B. ADDRESS

3023 Eastern Ave.

23C. DATE SIGNED

8/14/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8/15/50

24C. NAME OF CEMETERY OR CREMATORY

1st. Evangelical Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 15 1950

REGISTRAR'S SIGNATURE

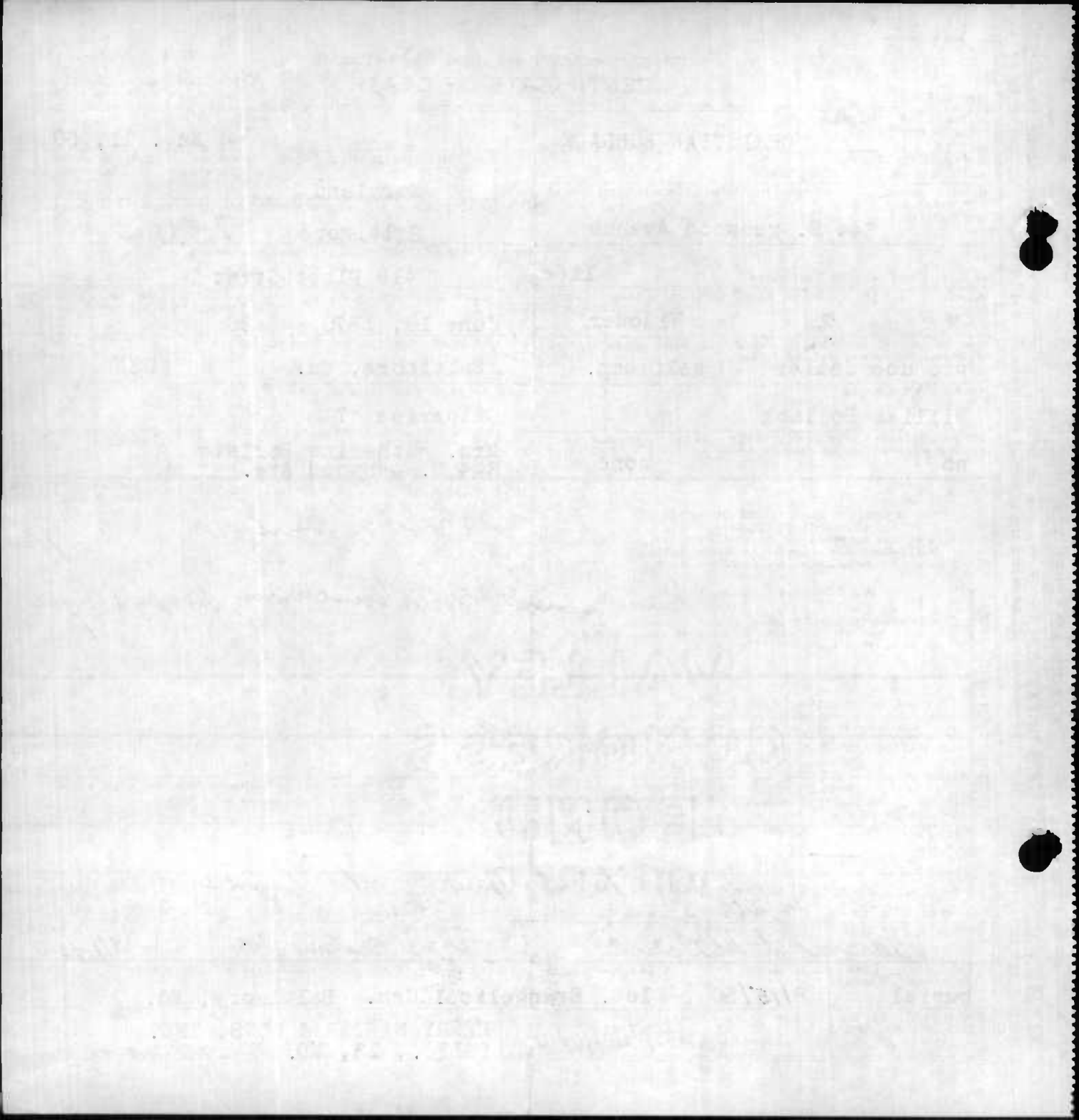
Thurston Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.
BALTO., 13, MD.

ADDRESS

Seigler Sander



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7058
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOLA B. WILSON

2. DATE
OF
DEATH Aug. 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2707 The Alameda

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2707 The Alameda

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Nov. 22, 1891

9. AGE (In years
last birthday)

58

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

homeworker

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Felix Wilson

14. MOTHER'S MAIDEN NAME

Florence Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Emma C. Wilson
2707 The Alameda

ADDRESS

18.

442 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertension - Cardiovascular disease

3 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1, 1950, to Aug. 14, 1950, that I last saw the deceased alive on Aug. 13, 1950 and that death occurred at 5:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Lloyd E. Sayles, M.D.

23B. ADDRESS

3902 Greenmount Ave.

23C. DATE SIGNED

Aug. 14, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8/17, 50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 15 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

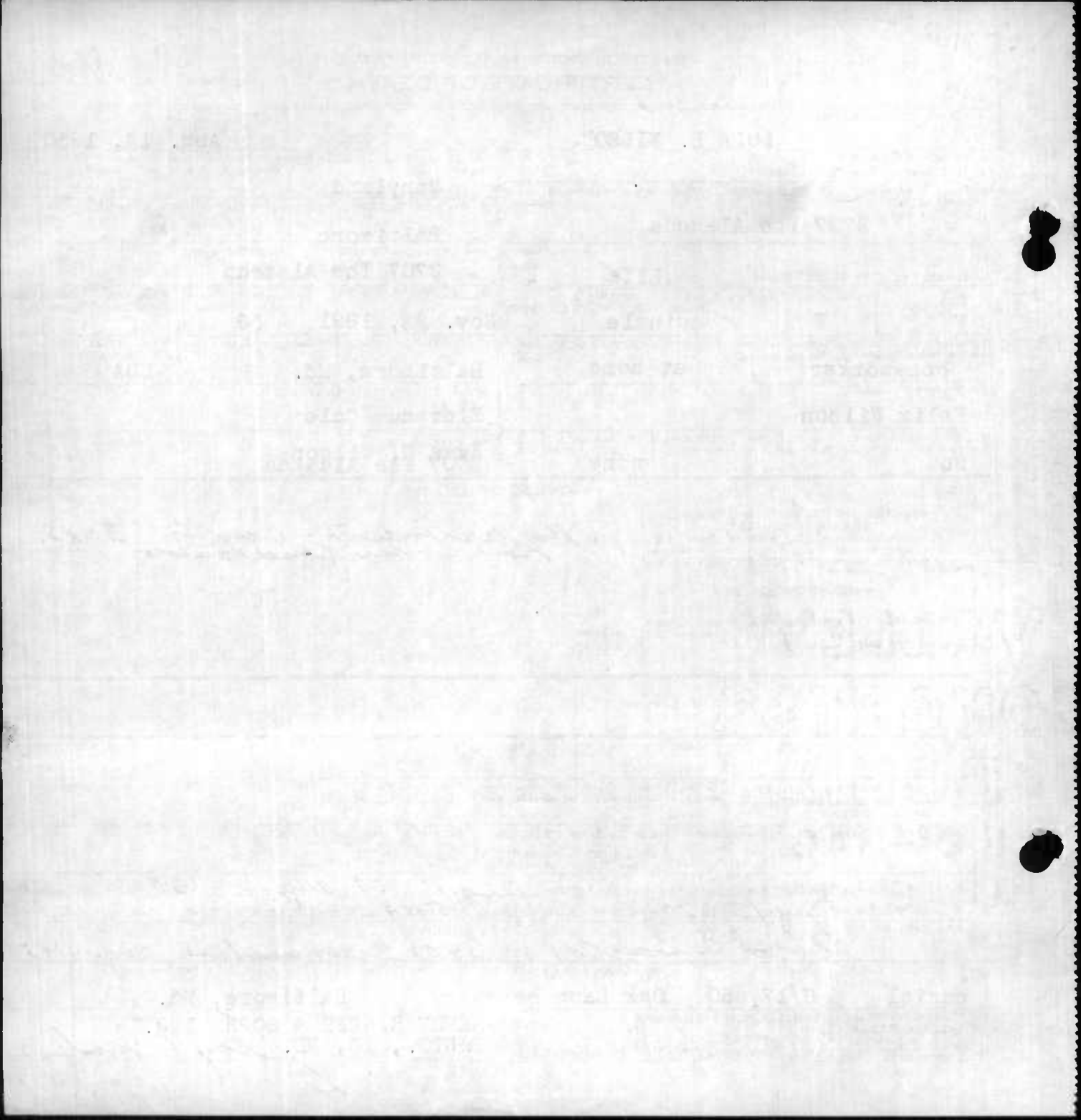
25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.

ADDRESS

BALTO., 13, MD.

Seay T. Sander



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-500
50 7059

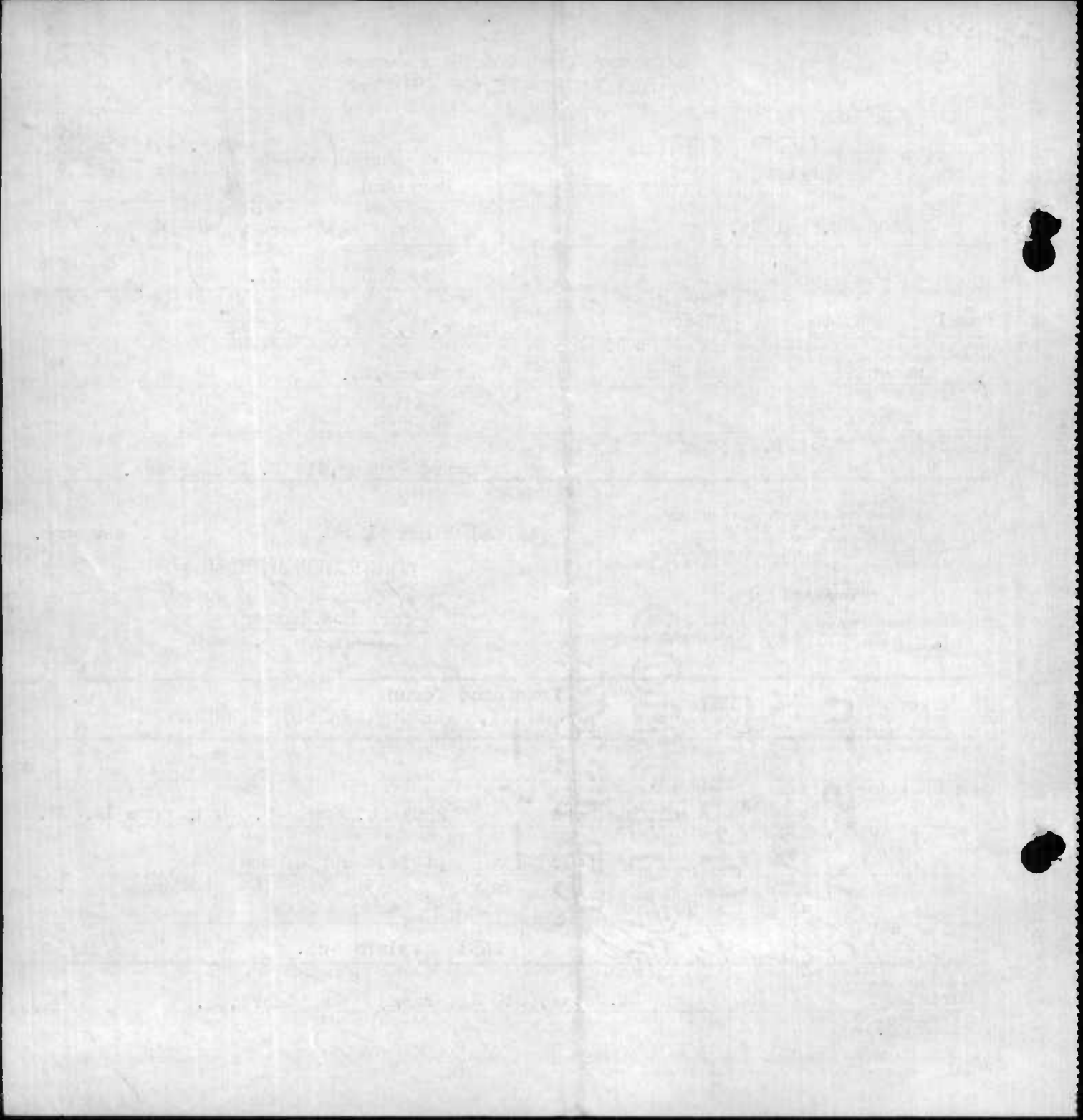
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7059
Registered No.

| | | | | | |
|--|----------------------------------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MINNIE FEENEY | | 2. DATE OF DEATH Aug. 14, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 2305 St. Paul St. | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-01 | | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 2928 Elliott St. | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Mar. 16, 1864 | 9. AGE (In years last birthday) 86 | If Under 1 Year Months Days If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Edward Feeney, 619 S. Decker Ave. | |
| 18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROSIS DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. fractured femur SENILITY, ARTERIOSCLEROSIS, DIABETES | | | | | INTERVAL BETWEEN ONSET AND DEATH sev. yrs. 1 mo. |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) in nursing home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2305 St. Paul St. Baltimore 18, Md. | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY July 5 1950 3 a. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? pt fell out of bed | |
| 22. I hereby certify that I attended the deceased from Jan , 19 50 to Aug/ 15 , 19 50 , that I last saw the deceased alive on Aug 13 , 19 50 and that death occurred at 5: a. m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE E. Ellsworth Cook M. D. | | 23B. ADDRESS 2431 Maryland Ave. | | 23C. DATE SIGNED 8/14/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/17/50 | | 24C. NAME OF CEMETERY OR CREMATORY St. Pauls, (5th Reformed) | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 24E. DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1950 | | 24F. REGISTRAR'S SIGNATURE Wm. Williams | |
| 24G. FUNERAL DIRECTOR 1217 St Paul St | | 24H. ADDRESS | | 24I. 186a | |

MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-16564

1. NAME OF DECEASED
(Type or Print)

KENNETH L. REELEY (BABY)

2. DATE
OF
DEATH

Aug 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, or institution: residence
before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTIMORE

25-52

D. STREET ADDRESS (If rural, give location)

2916 GEORGETOWN RD.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

-

8. DATE OF BIRTH

8-10-50

9. AGE (In years
last birthday)If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.

3

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Clarence

14. MOTHER'S MAIDEN NAME

Francis Triplett

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Massive G. I. Hemorrhage

40 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hemorrhagic disease of Newborn

Life

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Renal failure

24 hrs

19A. DATE OF OPERATION

8-12-50

19B. MAJOR FINDINGS OF OPERATION

Blood in G I tract, ? Gastric ulceration

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-11, 1950, to 8-13, 1950, that I last saw the
deceased alive on 8-13, 1950, and that death occurred at 6:10 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Edward W. Hopkins M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-14-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/15/50

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county)

Jorsey

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1214 E. Row

Box 11-1150

Leahurst - Leahurst, Iowa

and

Leahurst

DEAR MRS. LEAHURST

Dear Sir

I am writing you

to inform you of the

24th

of the

of the

of the

of the

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7061

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Albert Hull

2. DATE
OF
DEATH

8/12/50

3. PLACE OF DEATH

Baltimore City, Maryland 1721 Byrd St

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Baltimore B. COUNTY No

5. FULL NAME OF HOSPITAL OR INSTITUTION

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Md

7. Length of stay in Baltimore

8. STREET ADDRESS (If rural, give location)

1721 Byrd St 24-04

9. SEX

10. COLOR OR RACE

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

12. DATE OF BIRTH

13. AGE (in years, last birthday)

14. Under 1 Year Months: Days

15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country)

19. CITIZEN OF WHAT COUNTRY?

20. FATHER'S NAME

21. MOTHER'S MAIDEN NAME

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

23. SOCIAL SECURITY NO.

24. INFORMANT

25. ADDRESS

26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

27. CAUSE OF DEATH

28. INTERVAL BETWEEN ONSET AND DEATH

29. ANTECEDENT CAUSES

30. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Coronary Occlusion

8/12/50

(B) Coronary Thrombosis

8/10-8/12

31. II

32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

33. DATE OF OPERATION

34. MAJOR FINDINGS OF OPERATION

35. AUTOPSY?

YES ☐ NO ☐

36. ACCIDENT, SUICIDE, HOMICIDE (Specify)

37. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

38. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

39. TIME (Month) (Day) (Year) (Hour) OF INJURY

40. INJURY OCCURRED

41. HOW DID INJURY OCCUR?

42. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

43. I hereby certify that I attended the deceased from 1946, 19, to 1950, 19, that I last saw the deceased alive on Aug 12, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

44. SIGNATURE

Walter Kohn

45. M. D.

46. ADDRESS

102 E. Fort An

47. DATE SIGNED

8/22/50

48. BURIAL, CREMATION, REMOVAL (Specify)

49. DATE

50. NAME OF CEMETERY OR CREMATORY

51. LOCATION (City, town, or county) (State)

52. DATE RECEIVED BY LOCAL REGISTRAR

53. REGISTRAR'S SIGNATURE

54. FUNERAL DIRECTOR

55. ADDRESS

56. AUG 15 1950

57. J. J. Baker

58. 1318 Longview

VS 150

6703C

94a

7500
5600

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | | | | | | |
|---|---------------------------------|---|---|---|--|---|---------------------------------|---------------------------------|
| BIRTH NO. | | | 1. NAME OF DECEASED (Type or Print) Ellastine M^{rs} Rae | | | 2. DATE OF DEATH Aug 12 1950 | | |
| 3. PLACE OF DEATH: a. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Md. b. COUNTY | | | | | |
| b. FULL NAME OF HOSPITAL OR INSTITUTION University Hosp. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. | | | 21-02 | | |
| c. Length of stay in Baltimore | | | d. STREET ADDRESS (If rural, give location) 512 Ancher St. | | | | | |
| 5. SEX Female | 6. COLOR OR RACE Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE | 8. DATE OF BIRTH Aug. 28, 1930 | | 9. AGE (In years last birthday) 19 | | # Under 1 Year Months: Days: | # Under 24 Hours Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Law Address | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Henry M^{rs} Rae | | | 14. MOTHER'S MARYDEN NAME Evelyn Gaskins | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Evelyn M^{rs} Rae | | ADDRESS 512 Ancher St. | | |
| 18. E981X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Gun shot Wound of Head DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C) | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | |
| 19A. DATE OF OPERATION Aug 12 1950 | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Front of 512 Parkin Street | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 12, 1950 6:45 P.m. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Firearms | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | | | | | |
| 23A. SIGNATURE William J. Smith | | | 23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR..... | | | 23C. DATE SIGNED Aug 13 1950 | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-16-1950 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or County) (State) Balto. Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE William J. Smith | | 25. FUNERAL DIRECTOR Mrs. Kath. P. Williams | | ADDRESS 322 N. Schroeder St. | | |

MB

1910

1/10

Aug 26/10

Aug 26/10

Aug 26/10

Aug 26/10

University of Chicago

Female of 20/10

Female of 20/10

Female of 20/10

Female of 20/10

Female of 20/10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-525
50 7063

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7063
Registered No.

| | | | | | |
|---|------------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) HERBERT JOHNSON | | | 2. DATE OF DEATH August 13, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-01 | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 423 Stricker Street N. | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Dec. 15, 1896 | 9. AGE (In years last birthday) 53 | If Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Coal Co. | 11. BIRTHPLACE (State or foreign country) Chester Town Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Johnson | | | 14. MOTHER'S MAIDEN NAME Emma Johnson | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Sadie Johnson ADDRESS 423 N. Stricker St. | | |

| | | |
|---|--|----------------------------------|
| 18. 073X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ischemic heart disease with aortic insufficiency | | INTERVAL BETWEEN ONSET AND DEATH |
| (A) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | |
|--|--|--|--|---|
| 19A. DATE OF OPERATION 8-17-50 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| | | | | |
|--|-----------------------------|--|---|--|
| 23A. SIGNATURE Stanley B. Dunsicker | | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> | | 23C. DATE SIGNED August 14, 1950 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-17-50 | 24C. NAME OF CEMETERY OR CREMATORY W. H. Paulsen, Inc. Balto. | 24D. LOCATION (City, town, or county) (State) Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1950 | | REGISTRAR'S SIGNATURE Thurston R. Williams | | 25. FUNERAL DIRECTOR Mrs. Kate R. Williams ADDRESS 322 N. Schroeder |

6836T

30E

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

1982-1983

1984

1985-1986

1987-1988

1989-1990

1991-1992

1993-1994

1995

1996

1997-1998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7064

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Jones

2. DATE
OF
DEATH

8-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

B. COUNTY

before admission)

VA.

V-43

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

University

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Williamsburg Box 583

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1898

9. AGE (In years
last birthday)

52

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

B W I

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George

14. MOTHER'S MAIDEN NAME

Catherine Shaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

none

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

William Jones -

18. 002X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Disseminated Tuberculosis

DUE TO

Pulmonary & Peritoneal

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Tuberculosis infection

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Massive bilateral pleural effusion 141

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-11, 1950 to 8-12, 1950 that I last saw the
deceased alive on 8-11, 1950, and that death occurred at 1 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Edwin M Hubbard

M. D.

23B. ADDRESS

University Shop

23C. DATE SIGNED

8-12-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8-15-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cem. Lansdowne

24D. LOCATION (City, town, or county)

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

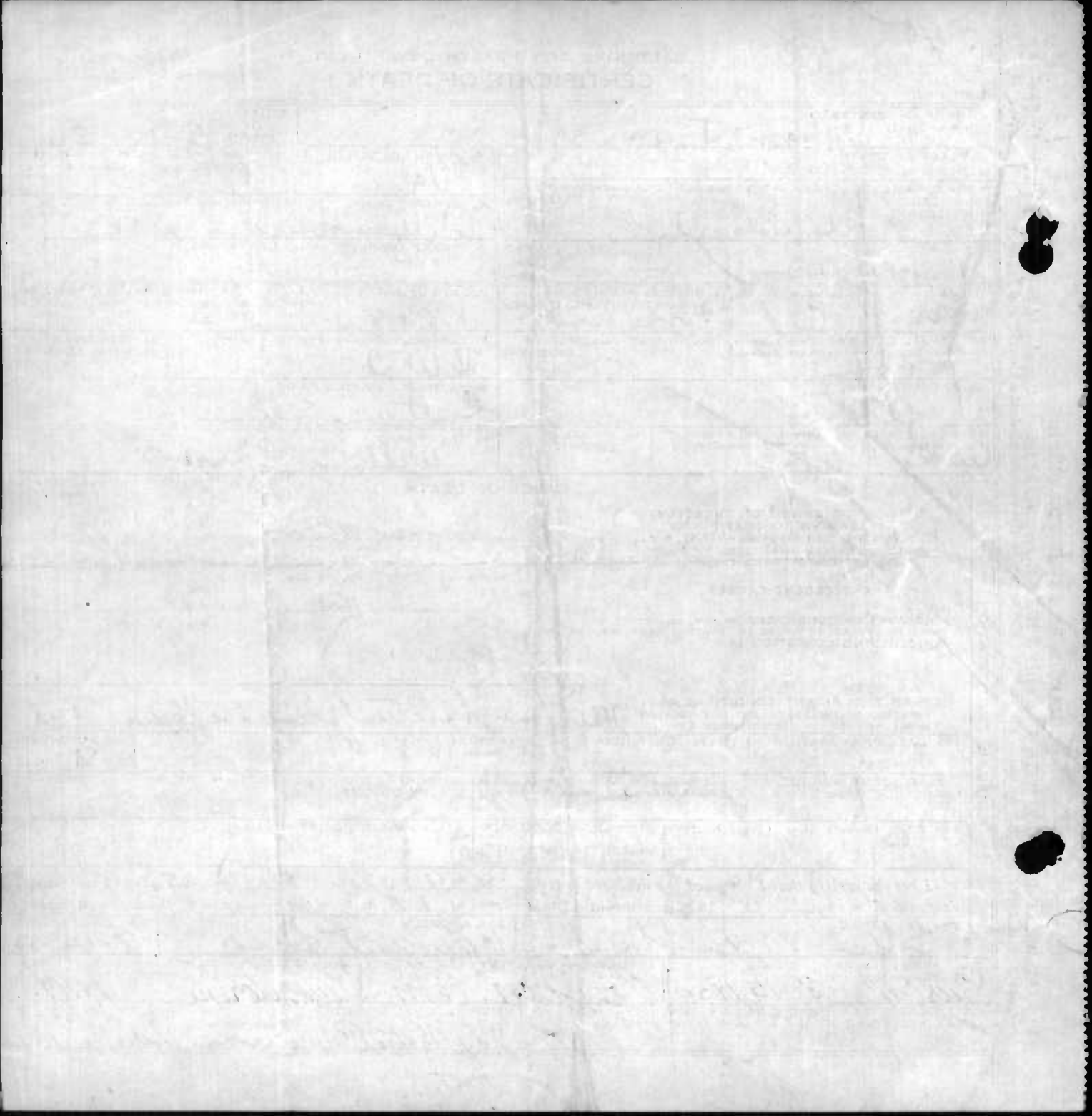
REGISTRAR'S SIGNATURE

William Jones

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Katie R. Williams Schwab St.



W-425

Wolgamuth

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7065

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CATHERINE JANE WOLGAMUTH

2. DATE
OF
DEATH

8/15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

UNION MEMORIAL HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

PARKTON

D. STREET ADDRESS (If rural, give location)

5300

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

NOV 13, 1885

9. AGE (In years
last birthday)

64

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE SCHWARTZ

14. MOTHER'S MAIDEN NAME

EMMA YINGST

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mama Mum Ray

18. 450.1 260 X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) GANGRENE, LEFT LEG

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROSIS, Generalized

DUE TO AND

(C) DIABETES MELLITUS

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

DECUBITUS ULCER, OVER SACRUM

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

6-19-50

19B. MAJOR FINDINGS OF OPERATION

GANGRENE, LEFT LEG

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUNE 6, 1950, to AUG 15, 1950, that I last saw the
deceased alive on AUG 15, 1950, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

8/15/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Aug 15/50

24C. NAME OF CEMETERY OR CREMATORY

Hallastown Pa

24D. LOCATION (City, town, or county)

Hallastown Pa

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 15 1950

REGISTRAR'S SIGNATURE

H. H. Williams, Jr.

25. FUNERAL DIRECTOR

Philip Herwig Sons

ADDRESS

2324 Calumet St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly supplied. The

MEDICAL CERTIFICATION

STATE OF CALIFORNIA
DEPARTMENT OF CORRECTIONS

12-2



B-600
50 7066

BOYER
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7066

BIRTH NO.

1. NAME OF DECEASED (Type or Print) *Rachel Boyer (Johnson)*

2. DATE OF DEATH *Aug 13, 50*

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE *Ind.* B. COUNTY *Baltimore*

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION *JOHNS HOPKINS HOSPITAL*

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Janeson 5300

7. STREET ADDRESS (If rural, give location)
124 E. Chesapeake Ave

8. Length of stay in Baltimore
Yrs. Mos. Days

9. SEX *Female* 10. COLOR OR RACE *Negro* 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Married*

12. DATE OF BIRTH *1893 Nov 13th 56* 13. AGE (in years last birthday) *57* 14. Under 1 Year Months: Days 15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Housewife* 17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country) *Ind* 19. CITIZEN OF WHAT COUNTRY?

20. FATHER'S NAME *Frank Johnson* 21. MOTHER'S MAIDEN NAME *Carrie ?*

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 23. SOCIAL SECURITY NO.

24. INFORMANT *JOHNS HOPKINS HOSPITAL* ADDRESS

18. *053.1* CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1. *Intestinal obstruction & GI hemorrhage*

2. *multiple disseminated abscesses*

3. *Staphylococcus aureus*

INTERVAL BETWEEN ONSET AND DEATH *3-4 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

1. *Staphylococcus aureus*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *2* 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug. 7, 1950* to *Aug. 13, 1950* that I last saw the deceased alive on *Aug 13, 1950* and that death occurred at *11:00 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE *Thomas J. Walsh* M. O. 23B. ADDRESS *JOHNS HOPKINS HOSPITAL* 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *Aug 16th 1950* 24C. NAME OF CEMETERY OR CREMATORY *Pleasant Rest* 24D. LOCATION (City, town, or county) (State) *Towson Md*

DATE RECEIVED BY LOCAL REGISTRAR *AUG 15 1950* REGISTRAR'S SIGNATURE *Huntington Williams, M.D.* 25. FUNERAL DIRECTOR *Mamie W. Wright* ADDRESS *721 Aisquith St*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

From autopsy findings,
If possible, state a
more definite
anatomical location
of the malignant tumor?

16020-70

Letter in document file 50-7066, 9/21/50.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7067

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anna M. Snyder

2. DATE
OF
DEATH

Aug. 13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

60 731 Grantley St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

47 yrs

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

731 Grantley St.

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

April 7, 1864

9. AGE (In years
last birthday)

86

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Adam Schettig

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ruth S. Thumm, 731 Grantley St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☒NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1950, to Aug 13, 1950, that I last saw the
deceased alive on 8/12, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John G. Schenck

M. D.

23B. ADDRESS

1337 S. Charles St.

23C. DATE SIGNED

8/15/50

24A. BURIAL, CREMA-
TION, OR OTHER (Specify)

Removal

24B. DATE

Aug. 16/50

24C. NAME OF CEMETERY OR CREMATORY

St. Patrick's Cemetery, Gallitzin, Pa.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

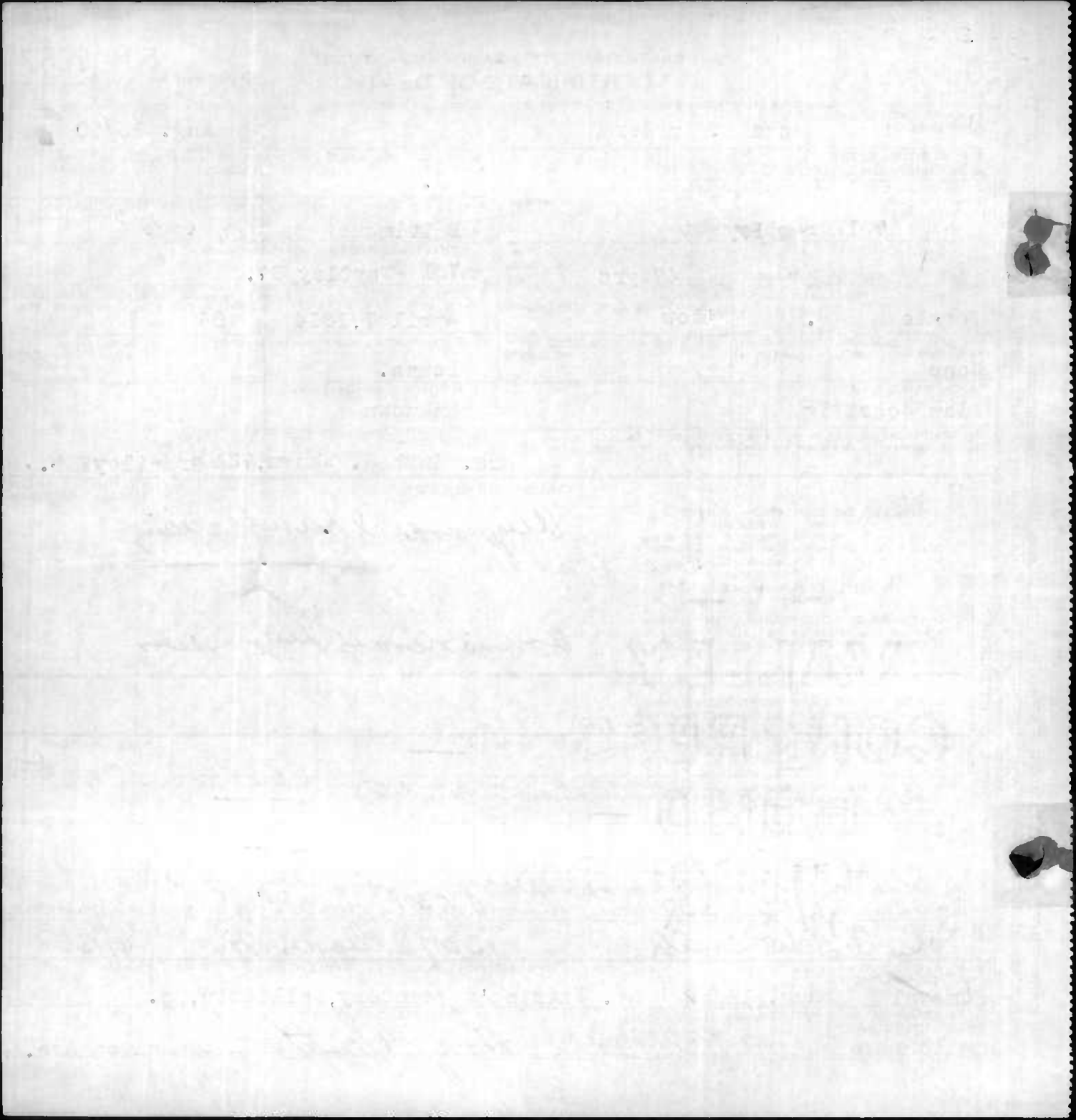
25. FUNERAL DIRECTOR

ADDRESS

Harry H. Smith, 4101 Edmondson Ave.

AUG 15 1950
VS 150

93D



5-530
50 7068BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7068
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Nellie Z. Smith

2. DATE
OF
DEATH

Aug. 11. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

100 Pontiac Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN

Baltimore 25-04

D. STREET ADDRESS (If rural, give location)

100 Pontiac Ave. Brooklyn

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 19. 1885

9. AGE (In years
last birthday)

65

10. Under 1 Year
Months: Days

7

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

✓

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Andrew

14. MOTHER'S MAIDEN NAME

Nancy Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

217-26-1576

17. INFORMANT

Harry Smith 100 Pontiac Ave

ADDRESS

18.

002X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Pulmonary Tuberculosis

INTERVAL BETWEEN
ONSET AND DEATH

2 1/2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 14, 1948, to Aug 11, 1950, that I last saw the
deceased alive on Aug 11, 1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Deibel, / John P. Urlock

M. D.

23B. ADDRESS

1226 West Astor St

23C. DATE SIGNED

8-14-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 14 1950

24C. NAME OF CEMETERY OR CREMATORY

Western Cemetery

24D. LOCATION (City, town, or county)

Edmondson Ave Md

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 15 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wendell Whippel 3125 Highland Ave

ADDRESS

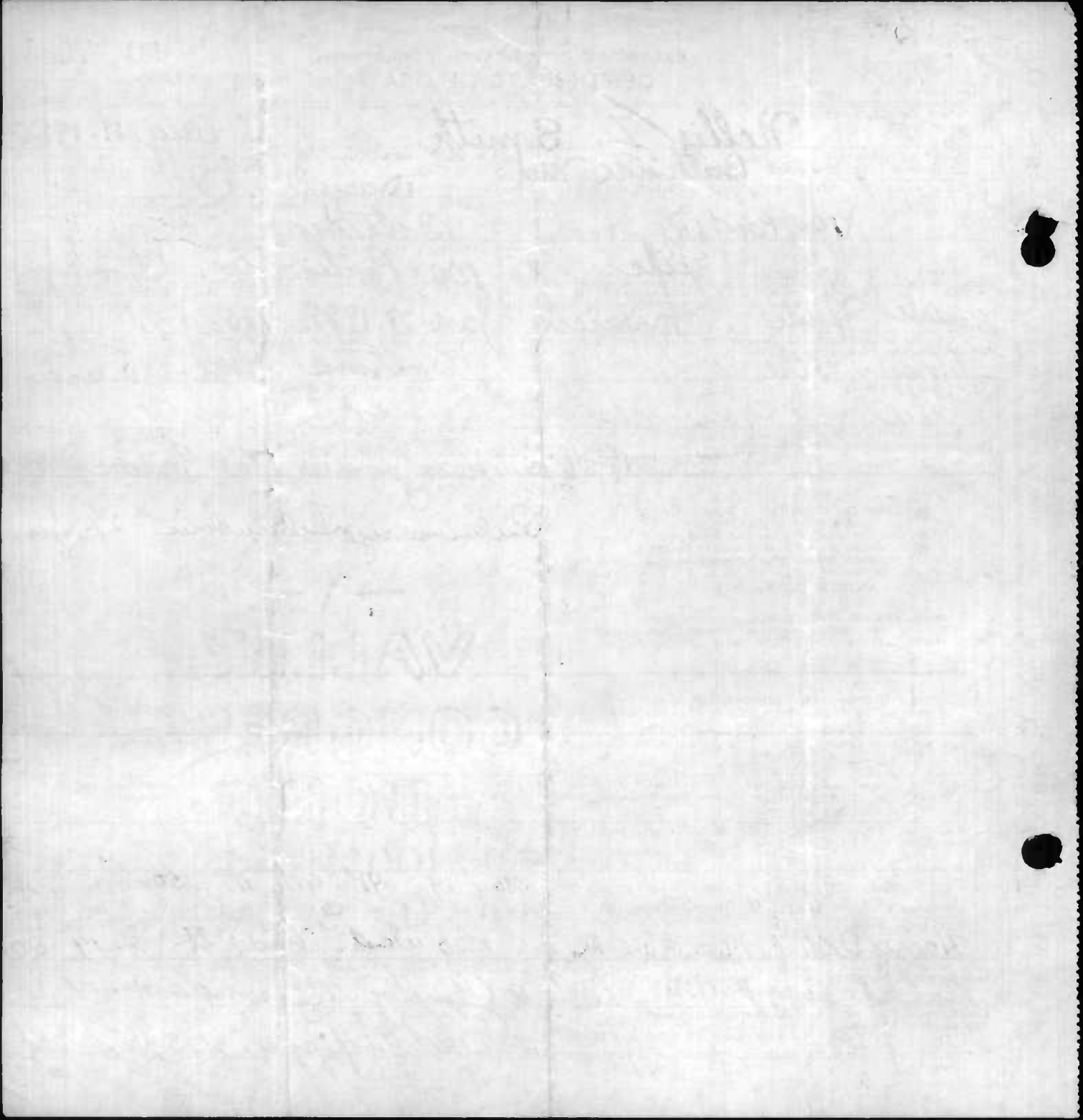
VS 150

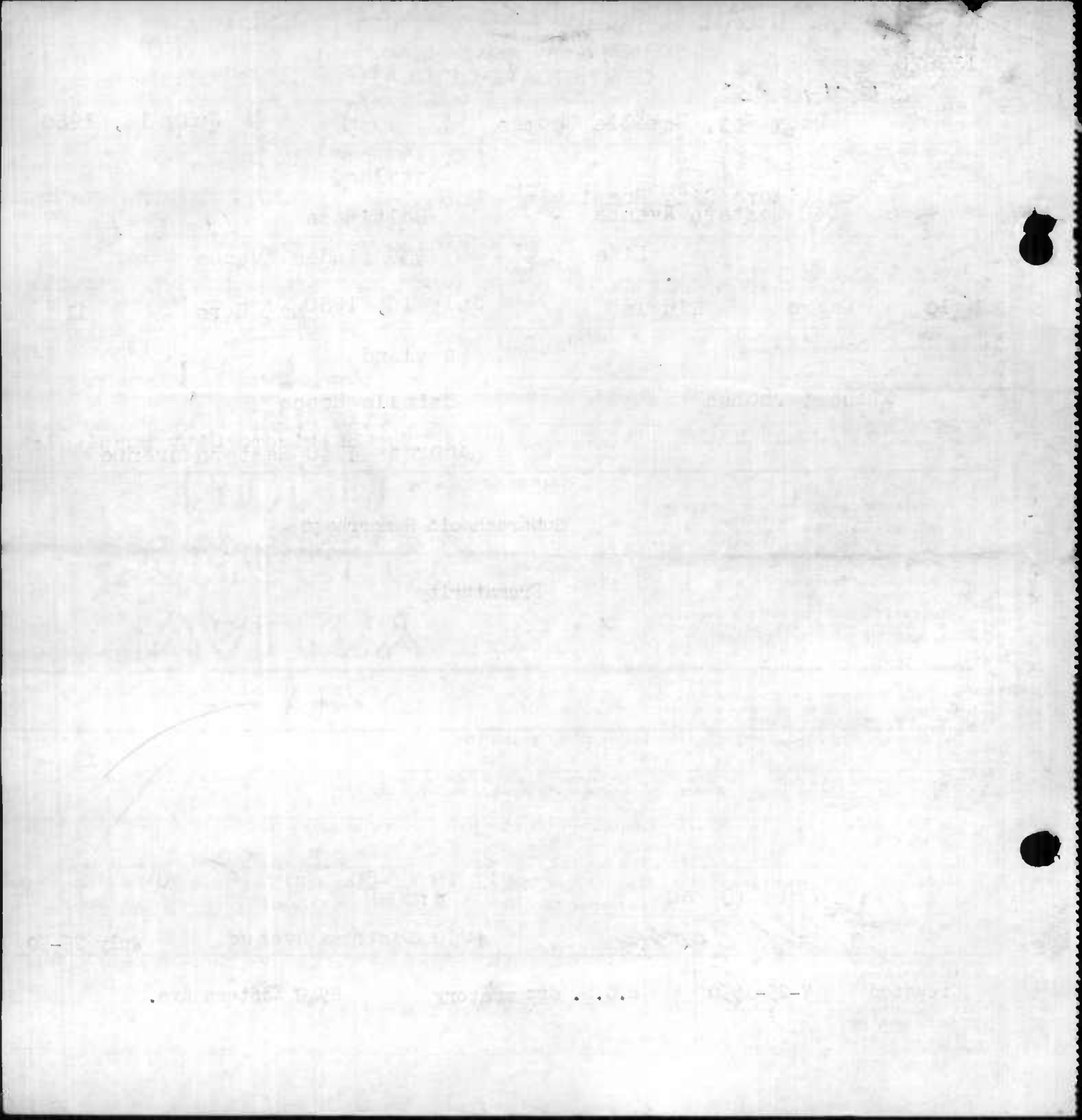
13B

are

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





50 7070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7070

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH M. DUNN

2. DATE
OF
DEATH

Aug. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

214 Sharp St.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

22-02

D. STREET ADDRESS (If rural, give location)

214 Sharp St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 30, 1890

9. AGE (In years
last birthday)

60

11 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Restaurant Operator

10B. KIND OF BUSINESS OR
INDUSTRY

Own business

11. BIRTHPLACE (State or foreign country)

Mexico

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John J. Dunn

14. MOTHER'S MAIDEN NAME

Katie Garland

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Myrtle Dunn, 214 S. Sharp St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

coronary artery disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Chronic alcoholism

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the
deceased alive on 7/19, 1950, and that death occurred at 7:00 A. m., from the causes and on the date stated above.

23A. SIGNATURE

R. W. Williams

M. D.

23B. ADDRESS

812 Brooks Lane

23C. DATE SIGNED

8/15/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/19/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 16 1950

REGISTRAR'S SIGNATURE

R. W. Williams, M.D.

25. FUNERAL DIRECTOR

Wm. Cook

ADDRESS

1217 St Paul St

VS 150

2906M

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-320

50 7071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7071

Registered No. _____

BIRTH NO. 50-16544

1. NAME OF DECEASED
(Type or Print)

DONALD FREDERICK MADDOX

2. DATE
OF
DEATH

AUG. 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

WOMAN'S Hosp.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

HOSP. FOR THE WOMEN OF MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

14-01

D. STREET ADDRESS (If rural, give location)

1517 PARK AV.

C. Length of stay in Baltimore

LESS THAN 1 DAY

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

AUG. 10, 1950

9. AGE (In years last birthday)

0

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

2 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

EARL MADDOX

14. MOTHER'S MAIDEN NAME

MARIE MAE MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

MOTHER

ADDRESS

SAME

18.

767.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ATELECTASIS - BILATERAL

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

2 HRS. 10 MIN.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

BILAT. POLYCYSTIC DISEASE OF KIDNEYS; RT. ING. HERNIA; L. HYDROCELL

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from AUG. 10, 1950, to AUG. 10, 1950, that I last saw the deceased alive on AUG. 10, 1950, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Robert R. Loeck

M. O.

23B. ADDRESS

Woman's Hosp.

23C. DATE SIGNED

AUG. 12, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS

AUG 14 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 16 1950

Huntington Williams, M.D.

Commissioner of Health

VS 150

161a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

35 week - term of
gestation

Birth wt - 5 lb 8 oz

Dr. Jacob said cause
was atelectasis

(by phone)

8-17-50

ED

5-520 50 7072 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 50 7072

BIRTH NO. 50-15684

| | | | |
|---|-------------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) BABY BY SIMS | | 2. DATE OF DEATH 8-1-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 19-02 | |
| c. Length of stay in Baltimore Yrs. 1 Mos. 1 Days | | D. STREET ADDRESS (If rural, give location) 212 N. CAREY. | |
| 5. SEX MALE | 6. COLOR OR RACE COLOURED | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 8-7-31-50 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) N.B. If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Horace Sims, Jr. | | 14. MOTHER'S MAIDEN NAME Mamie Bailey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mamie Sims | | ADDRESS | |

| | | |
|---|--|--|
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Prematurity DUE TO | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) DUE TO | | |
| 19A. DATE OF OPERATION 2 | | 19B. MAJOR FINDINGS OF OPERATION |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from 7/31 , 19 50 , to 8/1 , 19 50 , that I last saw the deceased alive on 7/31 , 19 50 , and that death occurred at 2:50pm. , from the causes and on the date stated above. | | |
| 23A. SIGNATURE J. E. Furman | 23B. ADDRESS University Hospital | 23C. DATE SIGNED 8/1/50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL |
| 24D. LOCATION (City, town, or county) (State) AUG 8 1950 | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1950 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Commissioner of Health |
| VS 150 | | 159 |

CERTIFICATE OF DEATH

State of New York, County of _____

I, _____, a duly qualified and licensed physician, do hereby certify that _____

was born on _____ at _____

and died on _____ at _____

of _____

caused by _____

at _____

and was buried on _____ at _____

in _____

and the cause of death was _____

as determined by _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

and the death was _____

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-16072

1. NAME OF DECEASED
(Type or Print)

Robert Ziegler

2. DATE
OF
DEATH

August 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1215 Shore Rd. # 20

c. Length of stay in Baltimore

6 days.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 3, 1950

9. AGE (In years
last birthday)10. Under 1 Year
Months Days

6

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Ziegler

14. MOTHER'S MAIDEN NAME

Joann Steman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Charles Ziegler, 1215 Shore Rd. # 20

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Bilateral Pyonephrosis and hydro-
ureter
Two diverticulae of urethra

(C)

INTERVAL BETWEEN
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-8, 1950 to 8-9, 1950 that I last saw the
deceased alive on 8-9, 1950 and that death occurred at 4:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Hamed Farfel

M. D.

23B. ADDRESS

Sinai Hospital, Baltimore

23C. DATE SIGNED

8-9-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL AUG 14 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

AUG 16 1950

VS 150

157H

THE STATE OF TEXAS

January 1, 1900

Report of the

Commissioner

of the

Land Office

for the year

1899

1899

1899

1899

1899

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1899

1899

1899

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1899

1899

1899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50-7074BIRTH NO. 10-151331. NAME OF DECEASED
(Type or Print) **BABY NICHOLSON**2. DATE OF DEATH **July 20, 1950**3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore**1215 Smithson Street**D. STREET ADDRESS (If rural, give location)
1215 Smithson Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

colored7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
single

8. DATE OF BIRTH

July 20, 1950

9. AGE (In years last birthday)

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.**-5**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Rufus Nicholson

14. MOTHER'S MAIDEN NAME

Isabelle ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. **762.0**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) **Neonatal asphyxia**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley S. Duncanson M.D.23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
July 21, 195024A. BURIAL, CREMA-
(N. REMOVAL) (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

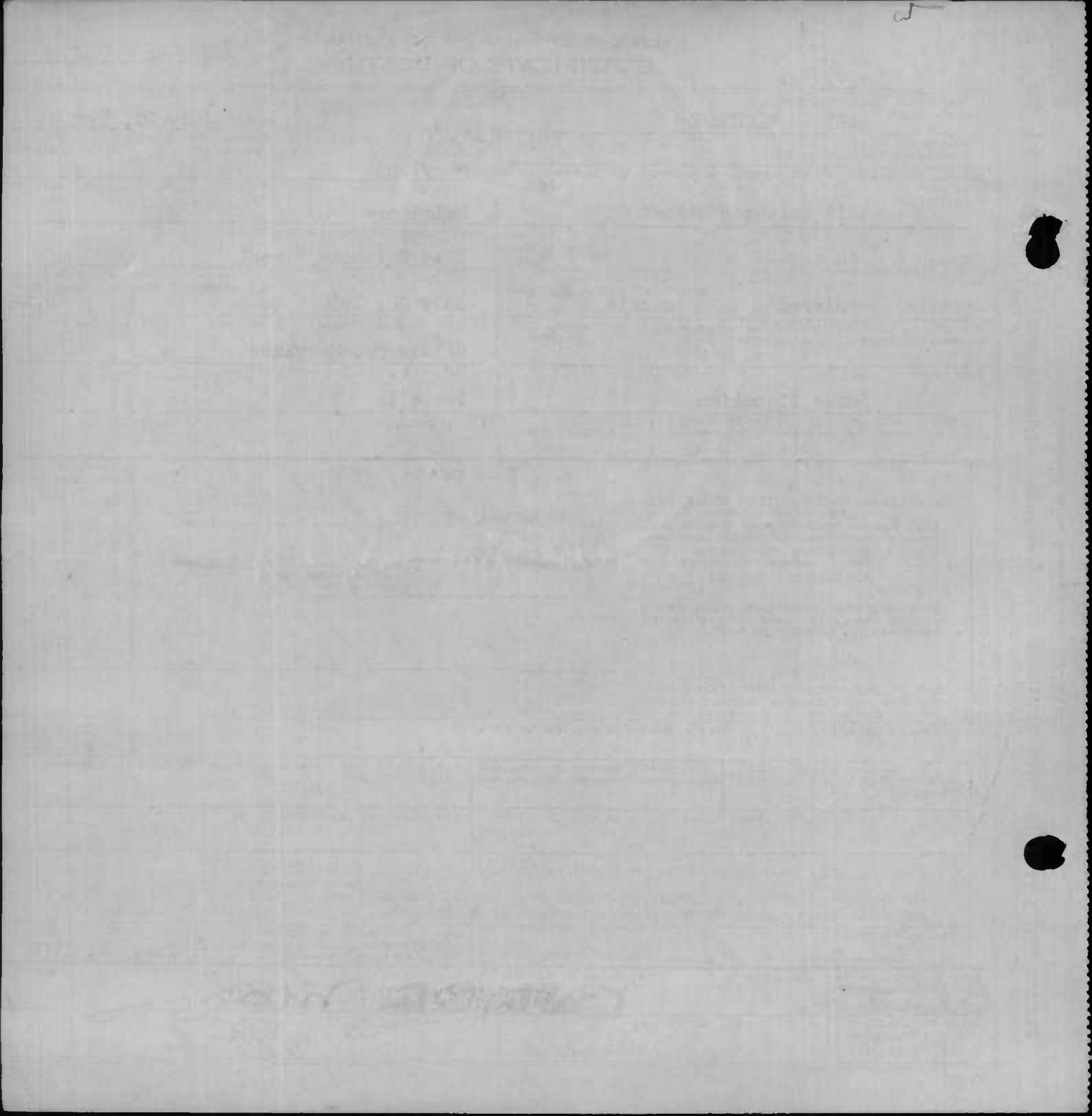
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ZENAS W. ALDERMAN

2. DATE
OF
DEATH

Aug 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

Montgomery

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

33

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Chevy Chase

D. STREET ADDRESS (If rural, give location)

4610 Lang CRUM LANE

6500

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

4-23-98

9. AGE (In years
last birthday)

52

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Dentist

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Zenias W. Alderman

14. MOTHER'S MAIDEN NAME

Elta Reeve

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Myocardial infarction, acute

9 hrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15, 1950, to 8-15, 1950, that I last saw the
deceased alive on 8-15, 1950, and that death occurred at 9 P.M., from the causes and on the date stated above.

23A. SIGNATURE

James C. Vandell, Jr.

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION (REMOVAL Specify)

Removal

24B. DATE

AUG-16/50

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Washington, D.C.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

Martin W. Hyung Co.

ADDRESS

Wash. D.C.

VS 150

03285

1300-N St. W.W.

94a

[Faint, mostly illegible handwriting across the page, possibly representing a list or ledger entries.]

[Faint handwriting at the bottom of the page, including what appears to be a date and a signature.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

ROBINSON

2. DATE
OF
DEATH

August 14, 1950

3. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF
HOSPITAL OR
INSTITUTION

619 Sewell Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE Maryland B. COUNTY before admission)C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 14-02D. STREET ADDRESS (If rural, give location)
619 Sewell Street

c. Length of stay in Baltimore

12

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 7, 1901

9. AGE (In years
1st birthday)

49

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ala.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robinson

14. MOTHER'S MAIDEN NAME

Costie Planzy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

418-18-3886

17. INFORMANT

Mattie Robinson

ADDRESS

Sevell St.

18. E981X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of back

DOE FOX

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Complete transection of spinal cord

DOE FOX

at level of T-12

(C) Chronic pyelonephritis

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)
In front of home21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

619 Sewell Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
January 28, 1950 8:1521E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

William V. Lovett

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 15, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/18/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

W. Halstead - 918 - ✓

V S 151

N-806.4

29068 Druid Hill Ave. 166

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,
January 10, 1911.

REPORT
OF THE
ATTORNEY GENERAL,
JAMES C. CLARK,
FOR THE YEAR
1910.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1911.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

WADE PRATER

2. DATE
OF
DEATH

8/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

322 Worsley St 12-04

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

322 Worsley St

c. Length of stay in Baltimore

40 yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan. 6, 1887

9. AGE (In years
last birthday)

63

10 Under 1 Year
Months: Days

7 8

11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR
INDUSTRY

Hair Cutting

11. BIRTHPLACE (State or foreign country)

Wards, S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wade Prater

14. MOTHER'S MAIDEN NAME

Betty

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Charles Lee 1606 Madison Ave

18.

442X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Cardio-Renal Disease*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *arteriosclerosis*
DUE TO(C) *Chronic Nephritis*

2 yrs.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1948, to Aug 14, 1950, that I last saw the deceased alive on Aug 14, 1950, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Charles A. Johnson

M. D.

23B. ADDRESS

2329 Guilford St.

23C. DATE SIGNED

Aug 15-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/19/50

24C. NAME OF CEMETERY OR CREMATORY

MT. CALVARY

24D. LOCATION (City, town, or county)

BALTO. MD

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Charles Perfer

ADDRESS

512 N. Carrollton A

VS 150

7408F

131a

WILLIAM

THOMAS

1-1

WILLIAM

THOMAS

1-1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7078

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

A. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

14. MOTHER'S MAIDEN NAME

17. INFORMANT ADDRESS

18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-10-1950 to 8-14-1950, that I last saw the deceased alive on 8-14-1950 and that death occurred at 2:06 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 16 1950

VS 150

93D

291-7-1

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ELIZABETH

(LYDIA)

M.

WEBB

2. DATE
OF
DEATH

August 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

824 W. Baltimore St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 1896

9. AGE (In years
last birthday)

54

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Peter Collison

14. MOTHER'S MAIDEN NAME

Mary Marslett

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Franklin Marslett 2507 E. Chase St.

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Hypertensive Cardiovascular Disease
with cardiac failure

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Smith

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Aug. 13, 1950

24A. BURIAL CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/18/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 16 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

WILLIAM COOK, INC.

ADDRESS

1214 St Paul St

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|----------------------------|--|---------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | |
| 4. Date of death | | 5. Time of death | | 6. Place of death | |
| 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | |
| 10. Signature of registrar | | 11. Signature of informant | | 12. Date of registration | |
| 13. Name of registrar | | 14. Name of informant | | 15. Name of physician | |
| 16. Name of hospital | | 17. Name of funeral home | | 18. Name of cemetery | |
| 19. Name of burial place | | 20. Name of burial place | | 21. Name of burial place | |
| 22. Name of burial place | | 23. Name of burial place | | 24. Name of burial place | |
| 25. Name of burial place | | 26. Name of burial place | | 27. Name of burial place | |
| 28. Name of burial place | | 29. Name of burial place | | 30. Name of burial place | |
| 31. Name of burial place | | 32. Name of burial place | | 33. Name of burial place | |
| 34. Name of burial place | | 35. Name of burial place | | 36. Name of burial place | |
| 37. Name of burial place | | 38. Name of burial place | | 39. Name of burial place | |
| 40. Name of burial place | | 41. Name of burial place | | 42. Name of burial place | |
| 43. Name of burial place | | 44. Name of burial place | | 45. Name of burial place | |
| 46. Name of burial place | | 47. Name of burial place | | 48. Name of burial place | |
| 49. Name of burial place | | 50. Name of burial place | | 51. Name of burial place | |
| 52. Name of burial place | | 53. Name of burial place | | 54. Name of burial place | |
| 55. Name of burial place | | 56. Name of burial place | | 57. Name of burial place | |
| 58. Name of burial place | | 59. Name of burial place | | 60. Name of burial place | |
| 61. Name of burial place | | 62. Name of burial place | | 63. Name of burial place | |
| 64. Name of burial place | | 65. Name of burial place | | 66. Name of burial place | |
| 67. Name of burial place | | 68. Name of burial place | | 69. Name of burial place | |
| 70. Name of burial place | | 71. Name of burial place | | 72. Name of burial place | |
| 73. Name of burial place | | 74. Name of burial place | | 75. Name of burial place | |
| 76. Name of burial place | | 77. Name of burial place | | 78. Name of burial place | |
| 79. Name of burial place | | 80. Name of burial place | | 81. Name of burial place | |
| 82. Name of burial place | | 83. Name of burial place | | 84. Name of burial place | |
| 85. Name of burial place | | 86. Name of burial place | | 87. Name of burial place | |
| 88. Name of burial place | | 89. Name of burial place | | 90. Name of burial place | |
| 91. Name of burial place | | 92. Name of burial place | | 93. Name of burial place | |
| 94. Name of burial place | | 95. Name of burial place | | 96. Name of burial place | |
| 97. Name of burial place | | 98. Name of burial place | | 99. Name of burial place | |
| 100. Name of burial place | | 101. Name of burial place | | 102. Name of burial place | |

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

50 7080

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EATON, GEORGE A.

2. DATE
OF
DEATH

8-14-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTIMORE MD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence
A. STATE B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE BALTIMORE MD

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

University Hosp

c. Length of stay in Baltimore

59

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

Subererville Md

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

6-9-59

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Asst. Supervisor

10B. KIND OF BUSINESS OR
INDUSTRY

State Hospital - Easton Ind.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Mrs. Evelyn Sperry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

260X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

HEART FAILURE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

myocardial infarction

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Diabetes Mellitus

INTERVAL BETWEEN
ONSET AND DEATHtell me
what this
is

infarction

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15-50, 19, to 8-14, 19, that I last saw the
deceased alive on 8-14, 19, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Warren Blaser

M. D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

8-15-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 17-1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Ind.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 16 1950

REGISTRAR'S SIGNATURE

Tunington Williams, M.D.

25. FUNERAL DIRECTOR

Manlio C. Syfer

ADDRESS

1600 W. North Ave.

orma 1685

50 7081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7081

Registered No.

| | | | | | |
|--|---------------------------|--|-------------------------------------|---|--|
| BIRTH NO. <u>460</u> | | 1. NAME OF DECEASED (Type or Print) <u>OLIVE GERTRUDE WHEELER</u> | | 2. DATE OF DEATH <u>8-15-50</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALT.</u> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>UPPERCO</u> | | | |
| c. Length of stay in Baltimore <u>60</u> Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) <u>5300</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE <u>MARRIED</u> WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <u>Sept 5-1913</u> | 9. AGE (In years last birthday) <u>36</u> | H Under 1 Year Months: Days H Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | 13. FATHER'S NAME <u>FRANK E. HOFFMAN</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNIE M. FLERINGER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT ADDRESS <u>Miss Lora Hoffman, Upperco Md</u> | |
| 18. <u>170X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>CARCINOMA OF BREAST & CEREBRAL METASTASES</u> (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> | | | |
| ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>6-16-50</u> 19 <u>50</u> , to <u>8-15-50</u> 19 <u>50</u> , that I last saw the deceased alive on <u>8-15-50</u> , 19 <u>50</u> , and that death occurred at <u>4:20</u> m., from the causes and on the date stated above. | | | | | |
| 22A. SIGNATURE <u>Francis J. Borges</u> | | 22B. ADDRESS <u>University Hospital</u> | | 22C. DATE SIGNED <u>8/15/50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>aug 17/50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u> | |
| 24D. LOCATION (City, town, or county) <u>Acadia - Balt Co Md</u> | | (State) <u>Md</u> | | | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 16 1950</u> | | REGISTRAR'S SIGNATURE <u>Thurston Williams, Jr.</u> | | 25. FUNERAL DIRECTOR ADDRESS <u>Edward C Tipton, Hampstead Md</u> | |

UNITED STATES DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY

1917-1918



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Jennie Grier Clayton

2. DATE
OF
DEATH

August 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1314 N. Stockton St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

1314 N. Stockton St.

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F E M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

January 7, 1901

9. AGE (in years
last birthday)

49

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George Lee

14. MOTHER'S MAIDEN NAME

Josephine Mason

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Flora Cager 4303 Washington St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Wa

INTERVAL BETWEEN
ONSET AND DEATH

(A) Carcinoma of left breast

10 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) previous carcinoma of right breast

3 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1949, to Aug 14, 1950, that I last saw the deceased alive on Aug 14, 1950, and that death occurred at 9:45 A. M., from the causes and on the date stated above.

23A. SIGNATURE

James L. Carr

M. D.

23B. ADDRESS

1427 Madison Ave.

23C. DATE SIGNED

8-15-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

Arlington

24D. LOCATION (City, town, or county)

Arlington Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

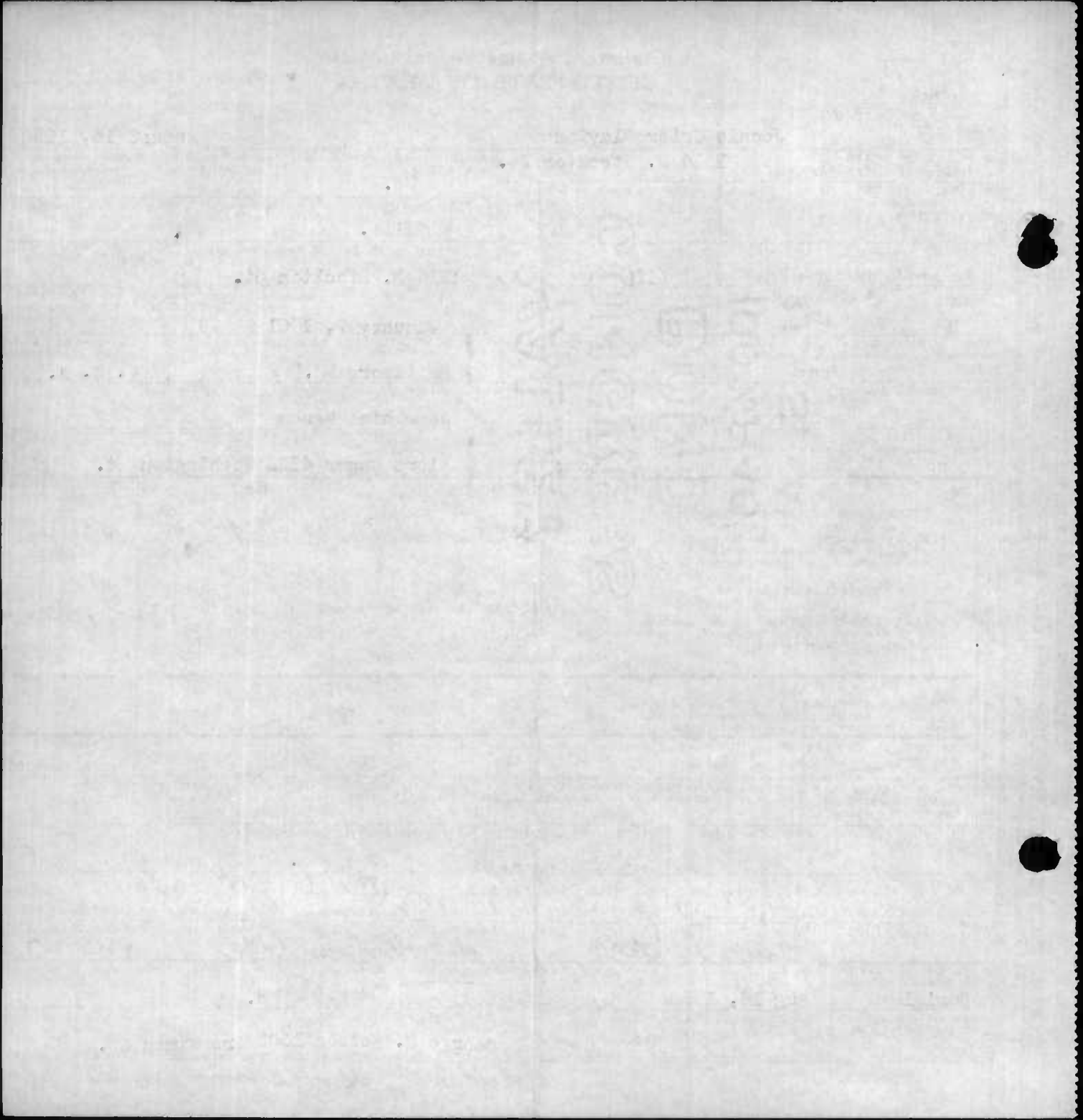
ADDRESS

George G. Kelson 1303 Presstman St.

VS 150

George G. Kelson

50



50 70831-623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7083
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GILMORE TROGDON

2. DATE
OF
DEATH

August 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital) or institution, give street address or location

Fort Armstead
Found at Patapsco River at

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

824 Greenmount Avenue

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

7-23-1902

9. AGE (In years
last birthday)

48

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Trogdon

14. MOTHER'S MAIDEN NAME

Ella Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Cordellia Tull 1825 E. Chase St.

18.

E929.81

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Found Drowned

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

harbor

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Patapsco River at Fort Armstead

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 14, 1950

a. m.

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Found drowned

22. I certify that I took charge of the remains described above, held an autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Quislander

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

August 16, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/16/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem

24D. LOCATION (City, town, or county)

A. G. Co

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William M. Williams

25. FUNERAL DIRECTOR

ADDRESS

Rayner Sanders 183

PLEASE WRITE PRECISELY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7084
Registered No. _____

BIRTH NO. 78-17422

1. NAME OF DECEASED
(Type or Print)

DEVLIN, Baby P. R. L.

2. DATE
OF
DEATH

Aug. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTIMORE

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

before admission

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

MERCY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1014 ME Allen Court

c. Length of stay in Baltimore

(life) one

5. SEX

4-

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Infant

8. DATE OF BIRTH

Aug. 15, 1950

9. AGE (In years last birthday)

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

Infant

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Andrew Devlin

14. MOTHER'S MAIDEN NAME

Rosalie ZIMMER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mother

ADDRESS

18. 76r.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

One Maternity
atalectasis

INTERVAL BETWEEN ONSET AND DEATH

one day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15, 1950, to Aug 15, 1950, that I last saw the deceased alive on Aug 15, 1950 and that death occurred at 9:15 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Mary E. Maltby

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

Aug 15, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 16, 1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Con

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

Aug 16/50

REGISTRAR'S SIGNATURE

Mary E. Maltby

25. FUNERAL DIRECTOR

Jo. Tarace 726 2013 Greenmount ave

ADDRESS

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------------------|--|-----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Race | | 4. Date of birth | | 5. Place of birth | |
| 6. Date of death | | 7. Time of death | | 8. Cause of death | | 9. Place of death | | 10. Signature of physician | |
| 11. Signature of registrar | | 12. Signature of informant | | 13. Signature of witness | | 14. Signature of funeral director | | 15. Signature of undertaker | |
| 16. Signature of coroner | | 17. Signature of jury | | 18. Signature of jury | | 19. Signature of jury | | 20. Signature of jury | |
| 21. Signature of jury | | 22. Signature of jury | | 23. Signature of jury | | 24. Signature of jury | | 25. Signature of jury | |
| 26. Signature of jury | | 27. Signature of jury | | 28. Signature of jury | | 29. Signature of jury | | 30. Signature of jury | |
| 31. Signature of jury | | 32. Signature of jury | | 33. Signature of jury | | 34. Signature of jury | | 35. Signature of jury | |
| 36. Signature of jury | | 37. Signature of jury | | 38. Signature of jury | | 39. Signature of jury | | 40. Signature of jury | |
| 41. Signature of jury | | 42. Signature of jury | | 43. Signature of jury | | 44. Signature of jury | | 45. Signature of jury | |
| 46. Signature of jury | | 47. Signature of jury | | 48. Signature of jury | | 49. Signature of jury | | 50. Signature of jury | |
| 51. Signature of jury | | 52. Signature of jury | | 53. Signature of jury | | 54. Signature of jury | | 55. Signature of jury | |
| 56. Signature of jury | | 57. Signature of jury | | 58. Signature of jury | | 59. Signature of jury | | 60. Signature of jury | |
| 61. Signature of jury | | 62. Signature of jury | | 63. Signature of jury | | 64. Signature of jury | | 65. Signature of jury | |
| 66. Signature of jury | | 67. Signature of jury | | 68. Signature of jury | | 69. Signature of jury | | 70. Signature of jury | |
| 71. Signature of jury | | 72. Signature of jury | | 73. Signature of jury | | 74. Signature of jury | | 75. Signature of jury | |
| 76. Signature of jury | | 77. Signature of jury | | 78. Signature of jury | | 79. Signature of jury | | 80. Signature of jury | |
| 81. Signature of jury | | 82. Signature of jury | | 83. Signature of jury | | 84. Signature of jury | | 85. Signature of jury | |
| 86. Signature of jury | | 87. Signature of jury | | 88. Signature of jury | | 89. Signature of jury | | 90. Signature of jury | |
| 91. Signature of jury | | 92. Signature of jury | | 93. Signature of jury | | 94. Signature of jury | | 95. Signature of jury | |
| 96. Signature of jury | | 97. Signature of jury | | 98. Signature of jury | | 99. Signature of jury | | 100. Signature of jury | |



50 7085 60

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7035

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Miller

2. DATE
OF
DEATH

8/15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

Victory House (N. 3rd & Heath St.)

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Aug. 9, 1897

9. AGE (In years
last birthday)

53

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

TRESSMAN

10B. KIND OF BUSINESS OR
INDUSTRY

NAT. EN. & S.P. CO.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Miller

14. MOTHER'S MAIDEN NAME

Adeline Loll

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No.

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

TAMIP - 706 Poulmar Av.

18. 4/20.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension, Coronary Artery
disease

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Emphysema, ad. RT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/14/50, 19, to 8/15/50, 19, that I last saw the
deceased alive on 8/15/50, 19, and that death occurred at 2:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. C. D. Quinn

23B. ADDRESS

1213 N. 3rd St.

23C. DATE SIGNED

8/15/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8-18-50

24C. NAME OF CEMETERY OR CREMATORY

CEDAR HILL

24D. LOCATION (City, town, or county) (State)

BALTIMORE

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. C. D. Quinn

25. FUNERAL DIRECTOR

ADDRESS

James L. L. L. L.

VS 150

6903D

130 E. FORT AVE.

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

PC 64516

3. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$ $\frac{1}{4} \times \frac{1}{4} = \frac{1}{16}$

50 7086 52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7086

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Uoinger

2. DATE
OF
DEATH

8-15-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland S.B.G.H.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

C. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

444 Patapoco Ave. 2504

5. SEX

M.

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 21

9. AGE (In years last birthday)

64

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Bakery

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Charles H. Usinger

14. MOTHER'S MAIDEN NAME

Elizabeth Frochlich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 156.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cirrhosis of liver

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 31, 1950, to August 15, 1954 that I last saw the deceased alive on 8-15, 1950, and that death occurred at 7:50 P.m., from the causes and on the date stated above.

23A. SIGNATURE

D. C. D. Quiring

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

50 7087 512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7087
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANKLIN S. THOMPSON

2. DATE
OF
DEATH 8/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland I450 William Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE Md. B. COUNTY before admission)B. FULL NAME OF
HOSPITAL OR
INSTITUTION
00C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

I450 William Street 24-03

c. Length of stay in Baltimore Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

4/29/1894

9. AGE (In years
last birthday)

56

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Tool Shed Operator

10B. KIND OF BUSINESS OR
INDUSTRY

Martins Co.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Franklin

14. MOTHER'S MAIDEN NAME

Dora Meseke

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

18.

331X1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE, (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

1 hr.

- 2 mo.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/14, 1950, to 8/14, 1950, that I last saw the
deceased alive on 8/14, 1950, and that death occurred at 1A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

B

8/17/50

London Park

Baltimore

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

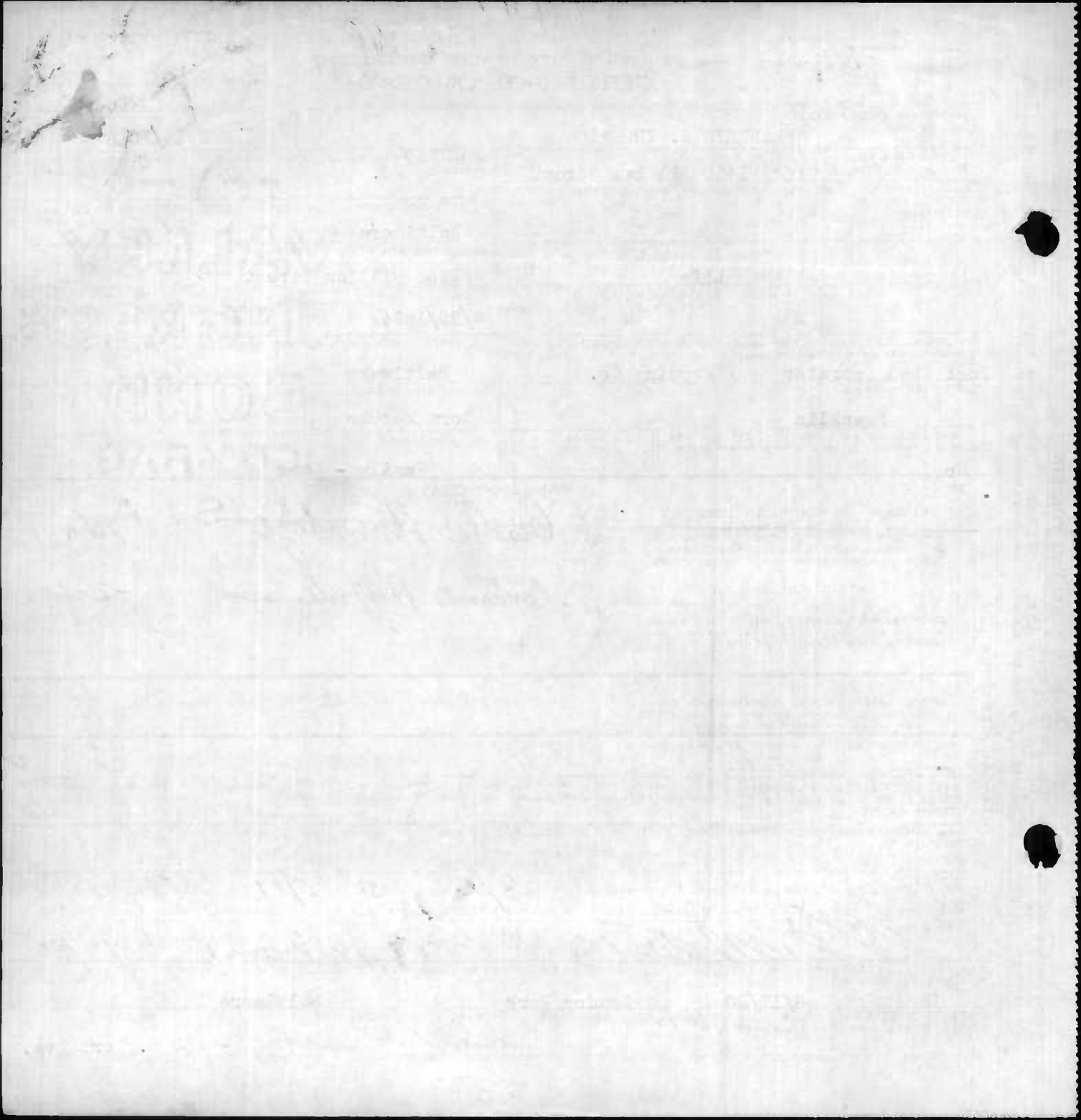
ADDRESS

- 130 E. Fort Ave.

VS 150

3903T

83a



50 7088

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7088

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLARA MAE HOBBS

2. DATE
OF
DEATH

8/16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

CATYON

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

MERCY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

WESTMINISTER

5600

D. STREET ADDRESS (If rural, give location)

ROUTE 6 WESTMINISTER, MD.

c. Length of stay in Baltimore

LIFE

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE (MARRIED)
WIDOWED-DIVORCED (Specify)

8. DATE OF BIRTH

7/31, 1876

9. AGE (In years
last birthday)

74

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

JAMES M SQUAY

14. MOTHER'S MAIDEN NAME

JULIA KAUFFMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADMISSION NOTE

ADDRESS

18.

162X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) FRACTURE LEFT FEMUR

9 WKS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) METASTATIC CARCINOMA

DUE TO

(C) CARDIAC FAILURE

3 WKS

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

R. Fisher

M.D.

19A. DATE OF OPERATION

JUNE 20, 1950

19B. MAJOR FINDINGS OF OPERATION

FRACTURE LEFT FEMUR

FEDERAL MEDICAL EXAMINER.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

HOME

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

ROUTE 6 WESTMINISTER

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

JUNE 12, 1950 ? m.

21E. INJURY OCCURRED

WHILE AT ☐NOT WHILE ☒

21F. HOW DID INJURY OCCUR?

Pt. SLIPPED AND FELL

to floor

22. I hereby certify that I attended the deceased from JUNE 12, 1950, to AUG 16, 1950, that I last saw the deceased alive on AUG 16, 1950, and that death occurred at 12 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Elden H. Carty

M.D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

8/16/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-19-50

24C. NAME OF CEMETERY OR CREMATORY

Springfield Cem.

24D. LOCATION (City, town, or county)

Sykesville, Penn., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

C. M. Wally Winfield, Md.

ADDRESS

VS 150

N-821.1

47D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

98-09006

" In your opinion
was fall, contributory
to death but not
to be considered cause
underlying it? Yes

Probably. - Bronchogenic Ca. of left lung."

See Document File 50 - 7088

9.20.50

CS

50 7089 B-300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7089

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alice H. Bayd

2. DATE
OF
DEATH

Aug. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1313 St. Lafayette Ave.

C. CITY OR TOWN

Baltimore

c. Length of stay in Baltimore

45 yrs.

D. STREET ADDRESS (If rural, give location)

1313 St. Lafayette Ave.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 7, 1882

9. AGE (in years
last birthday)

68

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Sellersburg, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Taylor

Munnally

14. MOTHER'S MAIDEN NAME

Alice Munnally

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

1-7-1 Bayd St. St. Lafayette Ave.

17. INFORMANT

A. J. Bayd St. St. Lafayette Ave.

ADDRESS 1313

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Thyroidosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Congestive heart failure 3 weeks

(C)

INTERVAL BETWEEN
ONSET AND DEATH

8.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 23, 1950, to Aug 15, 1950 that I last saw the
deceased alive on Aug. 14, 1950 and that death occurred at 4 A. M., from the causes and on the date stated above.

23A. SIGNATURE

George Mc Donald

23B. ADDRESS

844 N Carey St

23C. DATE SIGNED

8/16/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 18, 1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Pk. Balto. Co. Md.

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 16 1950

REGISTRAR'S SIGNATURE

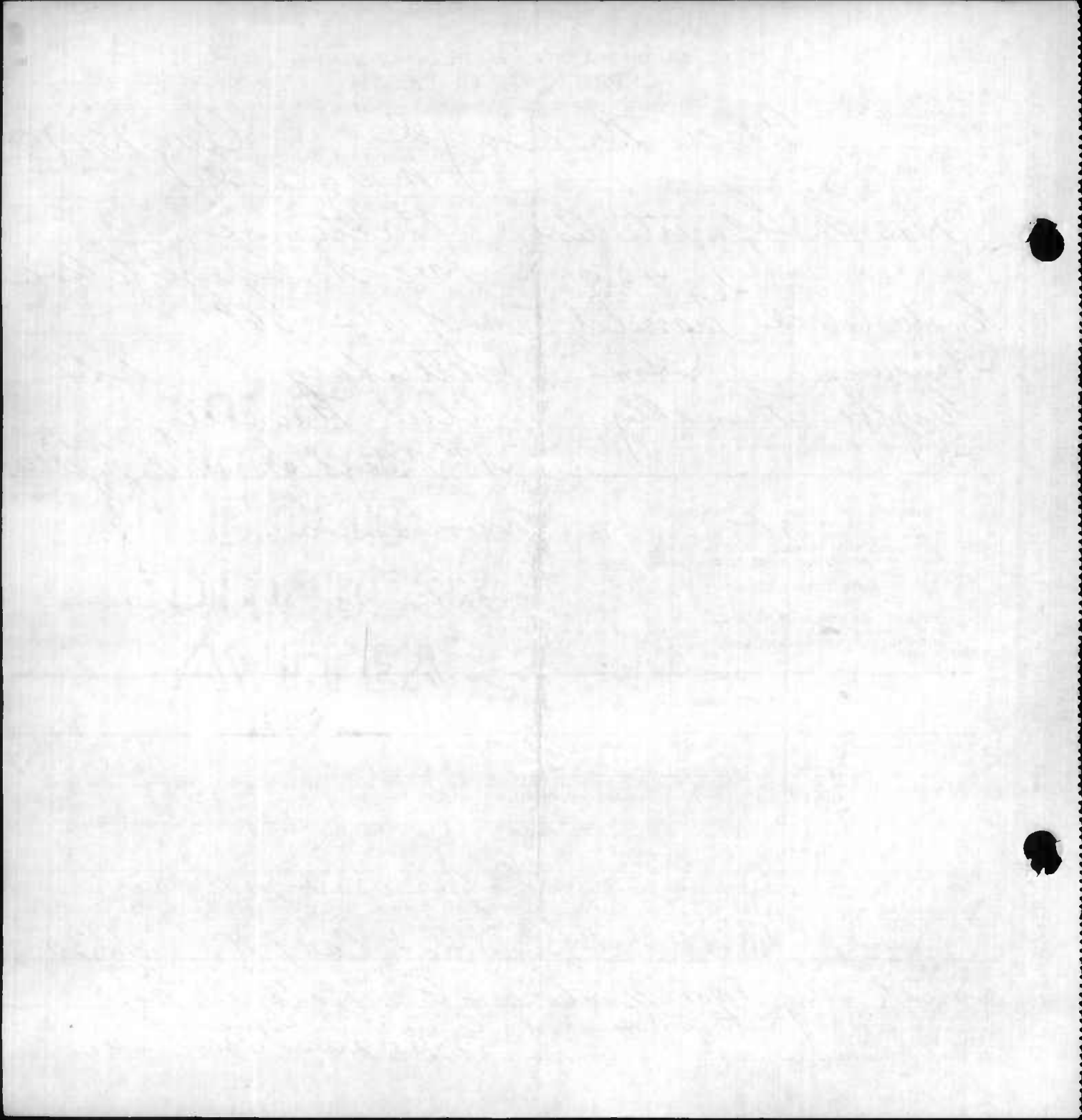
Wilmington, Delaware

25. FUNERAL DIRECTOR

George J. A. Eschman Jr.

ADDRESS

1735 David Hill Ave.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7090
S-216

50 7090

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

THEODORE SCHEFFER

2. DATE
OF

DEATH August 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3047 Abell Ave.,

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3047 Abell Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Yrs.
Mos.
Days

c. Length of stay in Baltimore Lifetime

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 11, 1865

9. AGE (In years last birthday)

84

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Grocery

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Ferdinand Scheffer

14. MOTHER'S MAIDEN NAME

Catherine Rever

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Emma Scheffer 3047 Abell Ave.,

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A)
DUE TO

Cerebral hemorrhage 8/11/50

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

Arteriosclerotic Cardio-Vascular disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1948, to Aug. 15, 1950, that I last saw the deceased alive on Aug 14, 1950, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 17, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

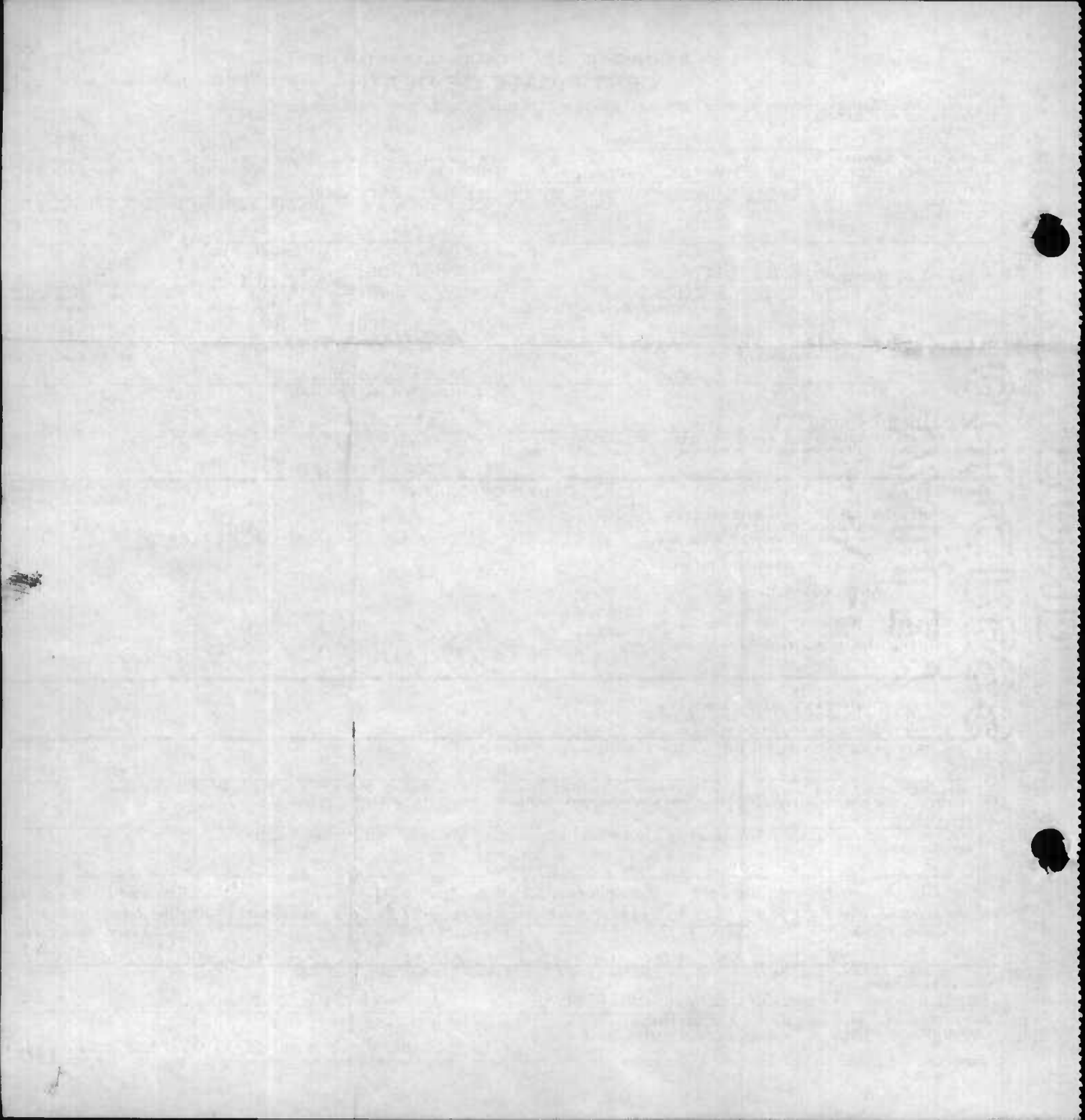
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2008 Orleans St.,



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

| | | | |
|---|---------------------------------|---|-------------------------------|
| BIRTH NO. 50 7091 1.460 | | 50 7091 | |
| 1. NAME OF DECEASED (Type or Print) <i>Jessie Taylor</i> | | 2. DATE OF DEATH <i>301565- AUG 16 1950</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHN HOPKINS HOSPITAL</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> | |
| D. STREET ADDRESS (If rural, give location) <i>926 Rutland Ave</i> | | 7-04 | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | 8. DATE OF BIRTH <i>7-23-17</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>colored</i> | 9. AGE (in years last birthday) <i>33</i> | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>S.C.</i> | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Arnon Wingate</i> | | 14. MOTHER'S MAIDEN NAME <i>Martha Mack</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>JOHN HOPKINS HOSPITAL</i> | | ADDRESS | |
| 18. <i>456X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Renal Failure</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Dis. Lupus Erythematosus 2 yrs.</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Tuberculosis adniti</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>7-21-</i> , 1950, to <i>8-16-</i> , 1950, that I last saw the deceased alive on <i>8-16-</i> , 1950, and that death occurred at <i>5:00 A</i> m., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE <i>Thomas J. Walsh</i> | | 23B. ADDRESS <i>JOHN HOPKINS HOSPITAL</i> | |
| 23C. DATE SIGNED | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 24B. DATE <i>Aug 16/50</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Hartsville S.C.</i> | | 24D. LOCATION (City, town, or county) (State) | |
| DATE RECEIVED BY REGISTRAR <i>AUG 16 1950</i> | | 25. FUNERAL DIRECTOR <i>Miss Corbett G. Elliott & Daugherty</i> | |
| REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i> | | ADDRESS <i>1129 N. Caroline St. 19</i> | |

Clara Rinal Fortis
Rice, Sugar and Flour

Tobacco and
Cigars

50 7092
T-300BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7092
Registered No.

| | | | | | | | | | |
|---|------------------------------|---|---|--|--|---|----------------------------------|-----------------------------------|---|
| BIRTH NO. | | | 1. NAME OF DECEASED (Type or Print) <u>ANNA E. TOD</u> | | | 2. DATE OF DEATH <u>8-15-50</u> | | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md.</u> B. COUNTY | | | | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Maryland</u> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto.</u> | | | | | | |
| C. Length of stay in Baltimore <u>46</u> Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) <u>Lutheran Hosp - Nurses Home</u> | | | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u> | 8. DATE OF BIRTH <u>-</u> | | | 9. AGE (In years last birthday) <u>56</u> | 10. Under 1 Year Months: Days | 11. Under 24 Hours Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>House Mother</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u> | | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>MOHAN</u> | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>-</u> | | | 17. INFORMANT <u>Miss E. Irene Perry</u> | | | ADDRESS <u>LUTHERAN HOSP OF MD.</u> |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) <u>Posterior myocardial infarction</u> DUE TO (B) <u>Arteriosclerotic Cardio-Vasc Disease</u> DUE TO (C) <u>Hypertensive Vascular Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>?</u> <u>?</u> | | | |
| 19A. DATE OF OPERATION <u>2</u> | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>8-14</u> , 19 <u>50</u> , to <u>8-15</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>8-15</u> , 19 <u>50</u> , and that death occurred at <u>m.</u> , from the causes and on the date stated above. | | | | | | | | | |
| 23A. SIGNATURE <u>Stanley K. Stembach</u> | | | 23B. ADDRESS M. D. <u>Lutheran Hosp of Md.</u> | | | 23C. DATE SIGNED <u>8-15-50</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 24B. DATE <u>8-18-50</u> | | | 24C. NAME OF CEMETERY OR CREMATORY <u>LOUDON PK CEM</u> | | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u> |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 16 1950</u> | | | REGISTRAR'S SIGNATURE <u>Wm. J. Tucker</u> | | | 25. FUNERAL DIRECTOR <u>Wm. J. Tucker & Sons Inc.</u> | | | ADDRESS <u>Balto md</u> |

764 ST

93D

DEPARTMENT OF HEALTH

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1914

REPORT

OF THE

COMMISSIONER OF HEALTH

FOR THE YEAR 1913

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

PRINTING OFFICE

1914

ALBANY

NEW YORK

1914

ALBANY

NEW YORK

1914

50 7093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7093

Registered No. _____

BIRTH NO. _____

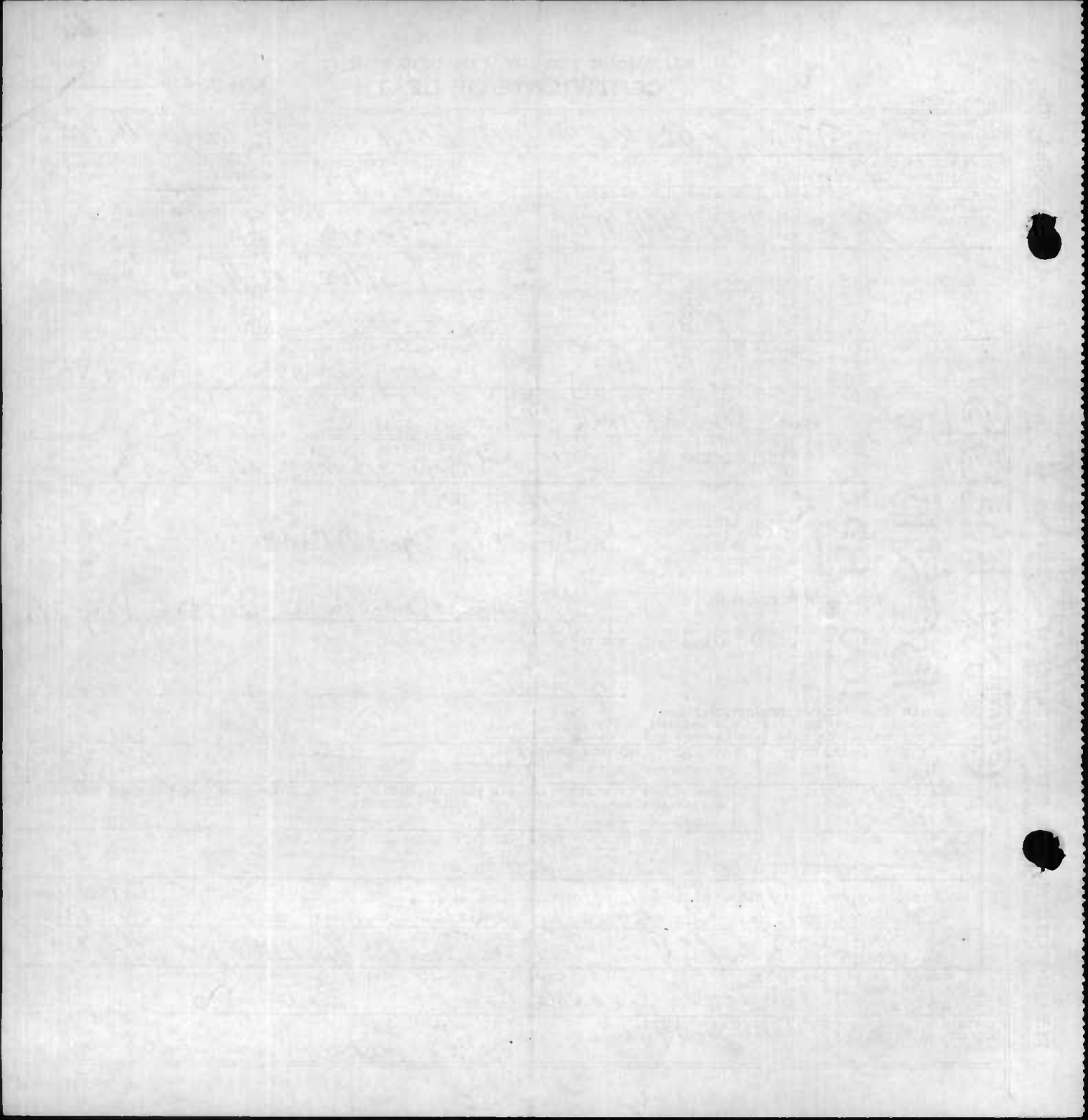
| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) FRANK HOLMES BUTTERFIELD | | | 2. DATE OF DEATH August 16, 1950 | | |
| 3. PLACE OF DEATH: a. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY _____ | | |
| b. FULL NAME OF HOSPITAL OR INSTITUTION 2801 Silver Hill Avenue | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. | | |
| c. Length of stay in Baltimore 33 Yrs. Mns. Days | | | d. STREET ADDRESS (If rural, give location) 2801 Silver Hill Avenue | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug. 5, 1883 | | 9. AGE (In years last birthday) 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Clothing (R) | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? United States |
| 13. FATHER'S NAME Benjamin Butterfield | | | 14. MOTHER'S MAIDEN NAME Jennie Holmes | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or of unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Mrs. Teyesa M. Foss 2801 Silver Hill Ave - 7- | | |

MEDICAL CERTIFICATION

| | | |
|--|--|---|
| 18. 4201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis DUE TO (A) _____ | | INTERVAL BETWEEN ONSET AND DEATH 8 months |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive Cardiovascular Disease DUE TO (B) _____ | | 15 years |
| (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19a. DATE OF OPERATION None | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) None | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **August 8, 1950**, to **August 16, 1950**, that I last saw the deceased alive on **August 16, 1950**, and that death occurred at **7:00** m., from the causes and on the date stated above.

| | | | | |
|--|---|--|--|------------------------------------|
| 23a. SIGNATURE Millard T. Trakard Jr. | | 23b. ADDRESS M. D. 3400 Woodbine Ave, Balt. 7, Md. | | 23c. DATE SIGNED 8/16/50 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE JUN 50 | 24c. NAME OF CEMETERY OR CREMATORY LORRAINE CEM. | 24d. LOCATION (City, town, or county) (State) BALTO. MD. | |
| DATE RECEIVED BY LOCAL REGISTRAR Aug 16 1950 | REGISTRAR'S SIGNATURE William Williams, Jr. | 25. FUNERAL DIRECTOR Wm. J. Tucker & Son | | ADDRESS Balto. Md. |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH CEIONOWSKI

2. DATE
OF
DEATH

August 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Baltimore City Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-12

D. STREET ADDRESS (If rural, give location)

Baltimore City Hospital Infirmary

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

U

9. AGE (In years
last birthday)

79

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

N

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

K

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

W

17. INFORMANT

W

ADDRESS

N

18.

E840 X1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Fracture of skull, ribs, and pelvis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C) Retroperitoneal hemorrhage

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Eastern Avenue near Newkirk Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 2, 1950 12.30

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by streetcar

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Dulechew

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 3, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL AUG 14 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

161950
VS 151

N-804, 2

171a 2

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO THE SECRETARY OF THE INTERIOR
WASHINGTON, D. C.
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SALT LAKE CITY, UTAH
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to the 'SALT LAKE CITY' area mentioned in the header. The text is organized into paragraphs and possibly includes a list or table of data, but the specific details cannot be discerned.]

Very truly yours,
[Illegible Signature]
Director, Bureau of Land Management

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | | | |
|--|---------------------------|--|--|---|------------------------------|
| 245 IC 139972 50 7095 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 50 7095 Registered No. | |
| BIRTH NO. 40-15796 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy- Laura Bessling | | | 2. DATE OF DEATH July 22, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Avenue | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-07 | | |
| c. Length of stay in Baltimore Life Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 1525 Bush Street | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH July 22, 1950 | 9. AGE (in years, Months, Days) New Born | 10. Under 1 Year 2 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Leo Bessling | | | 14. MOTHER'S MAIDEN NAME Laura Reed | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Records* Baltimore City Hospitals 4940 Eastern Avenue | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Prematurity DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 22, 1950, to July 22, 1950, that I last saw the deceased alive on July 22, 1950, and that death occurred at 5:45 AM from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE J. Logan | | 23B. ADDRESS 4940 Eastern Avenue | | 23C. DATE SIGNED 7-25-1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated | | 24B. DATE July 7-1950 | | 24C. NAME OF CEMETERY OR CREMATORY B.C.H. Crematory | |
| 24D. LOCATION (City, town, or county) 4940 Eastern Ave. | | 24E. DATE RECEIVED BY LOCAL REGISTRAR | | | |
| 24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS | | | |
| AUG 16 1950 | | | | | |

M. J. L. L. L.
Aguirre

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7096

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

REGINA ROSENBERG

2. DATE
OF
DEATH

8-15-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

1613 East Baltimore St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 3-01

D. STREET ADDRESS (If rural, give location)
1613 E. Baltimore St

c. Length of stay in Baltimore

46

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Fred Rosenberg - 3806 W. Cold Spring Lane

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Occlusion Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease with myocardial infarction 1946 Date

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1946, to Aug 15, 1950, that I last saw the deceased alive on 15 August 1950, and that death occurred at 335 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

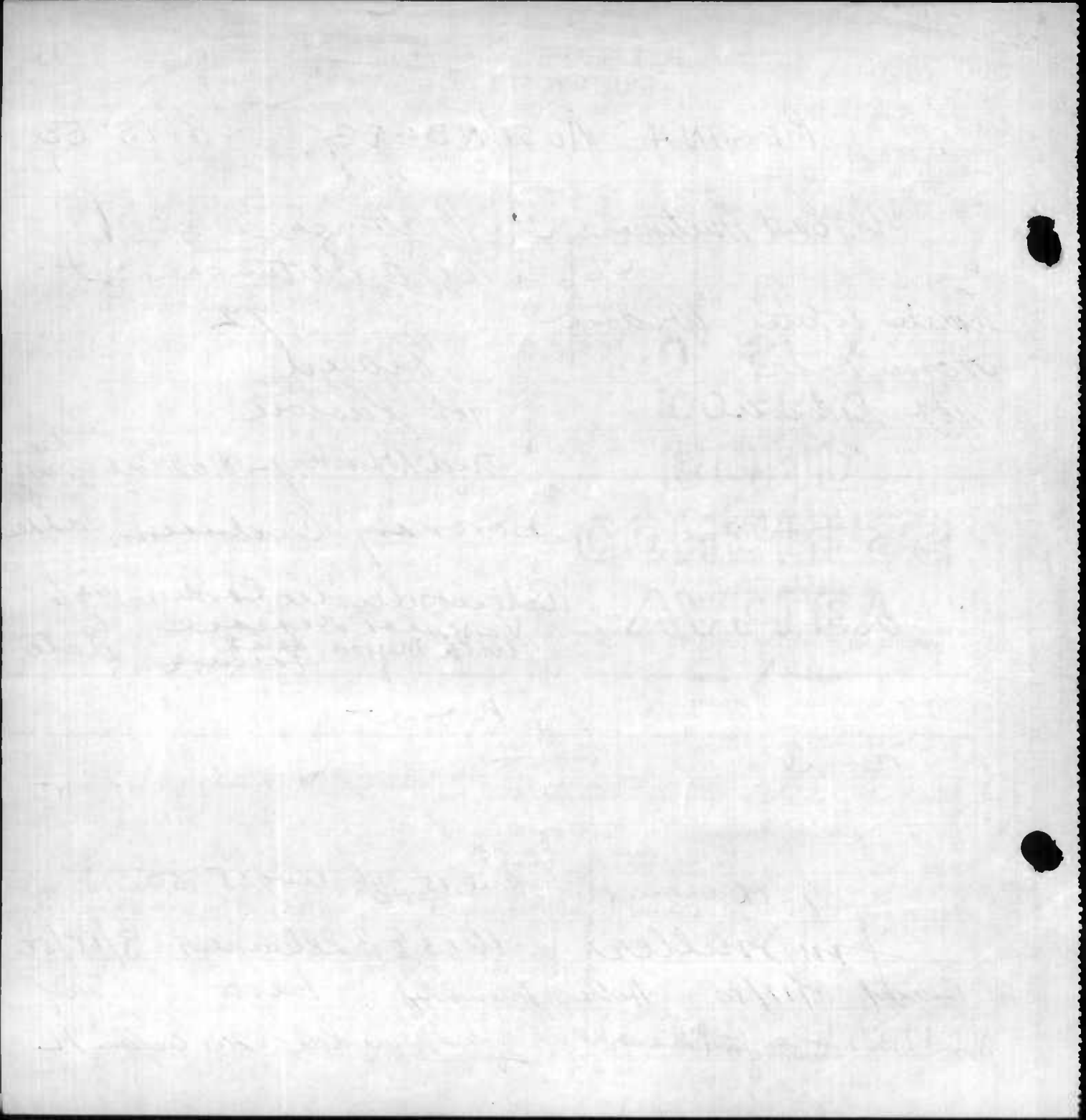
ADDRESS

VS 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7097

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Nathan Fishlow

2. DATE
OF
DEATH

AUG 16 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

not known

5. SEX

male

6. COLOR OR RACE

white H.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

3-18-80

9. AGE (In years last birthday)

70

If Under 1 Year

If Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

not known

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

not known

12. CITIZEN OF WHAT COUNTRY?

not known

13. FATHER'S NAME

not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Arteriosclerotic Cardio-vascular Disease

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Calcific Pericarditis

INTERVAL BETWEEN ONSET AND DEATH

years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14-1950 to 8-16-1950 that I last saw the deceased alive on 8-16-1950 and that death occurred at 2:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

David Lukens M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/17/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Tholom

24D. LOCATION (City, town, or county)

Baltimore

(State)

Mary

DATE RECEIVED BY LOCAL REGISTRAR

AUG 17 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis Inc - 2400 Eutan Rd

ADDRESS

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

10

7

8-16-21

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. 50-157921. NAME OF DECEASED
(Type or Print)

Baby Boy Simmons

2. DATE
OF
DEATH

8-9-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Baltimore City Hospitals

4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 25-05

D. STREET ADDRESS (If rural, give location)

1504 Sycamore St. zone 26

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

8-3-1950

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days
611 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Simmons

14. MOTHER'S MAIDEN NAME

Dorothy Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT Baltimore City Hospitals
Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Behar Pneumonia Bronchopneumonia

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

E. Coli

E. Coli septicaemia

(over)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3-1950 to 8-9-1950, that I last saw the
deceased alive on 8-9-1950 and that death occurred at 6.55A.m., from the causes and on the date stated above.

23A. SIGNATURE

H. Crozer

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

8-9-1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Cremated

24B. DATE

8-10-50- 9am Baltimore City Hospitals 4940 Eastern Ave. Balto. Md.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Correction :- See Document File 5a-7098

es 8-24-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7099

BIRTH NO. 50-14827

| | | | | | |
|---|------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Gregory Wilson | | | 2. DATE OF DEATH 8-7-1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore Life | | | D. STREET ADDRESS (If rural, give location) 1340 W. Lafayette Ave. zone 17 | | |
| 5. SEX M | 6. COLOR OR RACE N | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH July 22-1950 | | 9. AGE (in years last birthday) 16 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME James Wilson | | | 14. MOTHER'S MAIDEN NAME Hessie Penn | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Ave. | | |

| | | | |
|---|---|---|--|
| MEDICAL CERTIFICATION | 18. 757.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congenital Absence of Kidneys DUE TO INTERVAL BETWEEN ONSET AND DEATH Since birth | | |
| | ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) _____ (C) _____ | | |
| | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| | 19A. DATE OF OPERATION 8-1-1950 | | |
| | 19B. MAJOR FINDINGS OF OPERATION Exploratory Laparotomy for establishment of diagnosis | | |
| 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 7-29- , 1950, to 8-7- , 1950, that I last saw the deceased alive on 8-7- , 1950, and that death occurred at 9.15 PM. , from the causes and on the date stated above. | | | |
| 23A. SIGNATURE <i>W. Rogers</i> | | 23B. ADDRESS 4940 Eastern Ave. | |
| 23C. DATE SIGNED 8-9-1950 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated | | 24B. DATE 8-10-50 -9am | |
| 24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals | | 24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave., Balto., Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1950 | | REGISTRAR'S SIGNATURE <i>Thurston Williams</i> | |
| 25. FUNERAL DIRECTOR | | ADDRESS | |

157H

100-100
100-100

AMTFR

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-15957

1. NAME OF DECEASED
(Type or Print)

Baby Boy Agurs, Beatrice

2. DATE
OF
DEATH

8-7-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION Baltimore City Hospitals
4940 Eastern Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2503 Woodbrook Avenue (17)

c. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

August 5, 1950

9. AGE (In years last birthday)

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edison Agurs

14. MOTHER'S MAIDEN NAME

Beatrice Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records* Balto. City Hospitals Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Sub-Archnoid Hemorrhage

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

Since Birth

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNOER- Lying ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-5 1950, to 8-7 1950, that I last saw the deceased alive on 8-7 1950 and that death occurred at 3:45 P., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-9-1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Cremated

24B. DATE

8-10-50 -9am

24C. NAME OF CEMETERY OR CREMATORY

Baltimore City Hospitals

24D. LOCATION (City, town, or county)

4940 Eastern Ave. Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1950

VS 150

160a

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7101

BIRTH NO. 50-16180

1. NAME OF DECEASED
(Type or Print)

ERNEST ANDREWS, JR.

2. DATE
OF
DEATH

Aug 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived (If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

12-04

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Union Memorial Hospital

c. Length of stay in Baltimore

8

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

July 31, 1950

9. AGE (In years last birthday)

11 Under 1 Year

11 Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Ernest Andrews

14. MOTHER'S MAIDEN NAME

Helen Solman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mother

Baltimore, Md.

18. 756.2 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis

DUE TO

4 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intestinal perforation

DUE TO

4 days.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Bronchopneumonia

2 days.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

August 4, 1950

Midgut malrotation; periduodenal adhesions; volvulus

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from August 4, 1950, to August 8, 1950, that I last saw the deceased alive on August 8, 1950, and that death occurred at 7:33 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

D. S. Boring

M. D. Union Memorial Hospital

Aug 9, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

cremated

8-9-50

Union Mem. Hosp.

Baltimore

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1950

W. J. Williams, Jr.

Nancy M. Aman, Dept. of Pathology

Be 7200

434

P

22³⁰—

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7102

BIRTH NO. 50-15914

1. NAME OF DECEASED
(Type or Print)

BABY BOY HOWARD

2. DATE
OF
DEATH

7-31-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cockeysville

D. STREET ADDRESS (If rural, give location)

5300

c. Length of stay in Baltimore

life 6 hrs.

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7-31-50

9. AGE (In years
last birthday)If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.

6 55

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Sidney Gerald Howard.

14. MOTHER'S MAIDEN NAME

Anna May Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mother Cockeysville, Md.

18. 776 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 31 July, 1950, to 31 July, 1950, that I last saw the
deceased alive on 31 July, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

D. Spence

23B. ADDRESS

M. D.

Union Memorial Hospital

23C. DATE SIGNED

8-5-50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8-6-50

24C. NAME OF CEMETERY OR CREMATORY

Union Mem. Hospital

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1950

Wilmington Williams, Md.

Wm. M. Auman, Dept of Pathology

UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250

OFFICE OF THE
DIRECTOR
OF THE
BUREAU OF
PLANT INDUSTRY
WASHINGTON, D. C.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7103

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEON MILLER

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

3700 Columbus Drive

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3700 Columbus Drive

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 15, 1910

9. AGE (in years,
last birthday)

40

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR
INDUSTRY

Ladies Clothing (R)

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Abraham Miller

14. MOTHER'S MAIDEN NAME

Leah ??

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sophie Miller-3700 Columbus Drive

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Carcinoma of colon

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

7 mos.

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Aug 16, 1950, that I last saw the
deceased alive on Aug 16, 1950, and that death occurred at 11-A m., from the causes and on the date stated above.

23A. SIGNATURE

Francis B. Dickey

M. D.

23B. ADDRESS

715 M. Charles St

23C. DATE SIGNED

Aug 16, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial,

24B. DATE

Aug. 17/50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Young Mens Ass.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Sol. Linnson & Bros

2644 26
W North Ave

AUG 17 1950

VS 150

2906E

46E

DEPARTMENT OF JUSTICE

WATLEY
CONFERENCE

8-1-1948

PLEASE WRITE PRECISELY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7104
Registered No. _____

236
50 7104
50-09642

| | | | | | |
|---|----------------------------------|--|--|---|---|
| BIRTH NO. _____ | | 1. NAME OF DECEASED (Type or Print) MARY Huster | | 2. DATE OF DEATH 8-16-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____ | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hosp. | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | D. STREET ADDRESS (If rural, give location) 412 N. Lakewood Ave. | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single | 8. DATE OF BIRTH May 16, 1950 | 9. AGE (In years last birthday) 3 | If Under 1 Year Months: _____ Days _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Charles E. Huster | | | 14. MOTHER'S MAIDEN NAME Wanda Beeman | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS parents, above | | |
| 18. 754.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CONGENITAL HEART DISEASE DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO _____ | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug 7 , 19 50 , to Aug 16 , 19 50 , that I last saw the deceased alive on Aug 16 , 19 50 , and that death occurred at 8 p.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Shirley Kramer | | 23B. ADDRESS Sinai Hosp. | | 23C. DATE SIGNED 8-16-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 17, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State) 4300 Old Fred'k. Rd., Balto. | | 25. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601-35 E. Madison St. | | | |

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ was born on _____ day of _____ 19____ at _____ Texas.

Witness my hand and seal of office this _____ day of _____ 19____.

County Clerk

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

CLIN ALFRED JONES

2. DATE
OF
DEATH

August 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2027 Maryland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

c. Length of stay in Baltimore

40 years

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2027 Maryland Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 21, 1887

9. AGE (In years last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stock Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Hopper McGaw Co.

11. BIRTHPLACE (State or foreign country)

Chester, Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.

13. FATHER'S NAME

Thomas Harry Jones

14. MOTHER'S MAIDEN NAME

Anna Hudnall

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Letha J. Jones, wife, 2027 Maryland Ave.

18.

150X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Carcinoma of Esophagus
Metastases to Lung

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

Indefinite
Known to be 3 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21a. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 17, 1950 to June 24, 1950, that I last saw the deceased alive on June 24, 1950, and that death occurred at 1:45 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 17, 1950

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Park

24D. LOCATION (City, town, or county)

Harford Rd., Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1950

Huntington Williams, M.D.

Schimunek Funeral Home, Inc.
2601-3-5 E. Madison St.

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

ESTATE

DEBTS

PROPERTY

INHERITANCE

WILLS

TESTAMENTS

EXECUTORS

ADMINISTRATORS

GUARDIANS

TRUSTEES

RECEIPTS

DISBURSEMENTS

ACCOUNTS

FINANCIAL STATEMENTS

TAX RETURNS

LEGAL OPINIONS

NOTARIAL CERTIFICATES

POWER OF ATTORNEY

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 7106

| | |
|---|---|
| BIRTH NO. _____ | |
| 1. NAME OF DECEASED (Type or Print) Leo Andrew Logue | |
| 2. DATE OF DEATH 8-15-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) South Baltimore General Hospital Baltimore | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| D. STREET ADDRESS (If rural, give location) 1003 Ridgely St | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | |
| 5. SEX M. | 6. COLOR OR RACE W. |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced | |
| 8. DATE OF BIRTH June 24, 1893 | 9. AGE (In years last birthday) 57 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10B. KIND OF BUSINESS OR INDUSTRY B+O.R.R. |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME John J. Logue | |
| 14. MOTHER'S MAIDEN NAME Mary Riley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | 16. SOCIAL SECURITY NO. 212-26-5833 |
| 17. INFORMANT Florence Brunner | |
| ADDRESS _____ | |
| 18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive C-V. Disease DUE TO _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO _____ | |
| 19A. DATE OF OPERATION 2 | |
| 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | 21D. TIME (Month) (Day) (Year) (Hour) |
| 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from 8-9 , 19 50 , to 8-15 , 19 50 , that I last saw the deceased alive on 8-15 , 19 50 , and that death occurred at 10 P.m. , from the causes and on the date stated above. | |
| 23A. SIGNATURE D. C. D. Brunner | 23B. ADDRESS 8-16-50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/19/50 |
| 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 24D. LOCATION (City, town, or county) (State) Balto. Md. |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1950 | REGISTRAR'S SIGNATURE Wm. Cook Inc. |
| 25. FUNERAL DIRECTOR ADDRESS 1217 St. Paul St. | |

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE

REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS

FOR THE YEAR
1900

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK
PRINTING OFFICE

1901

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK
PRINTING OFFICE

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7107

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Emma Dell

2. DATE
OF
DEATH

8-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONBalto. City Hospitals
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3025 Windsor Avenue

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 7, 1861

9. AGE (In years last birthday)

88

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Bremer

14. MOTHER'S MAIDEN NAME

Shirley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records* Balto. City Hospitals Eastern Ave

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Cerebral Thrombosis

(A) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

CERTIFICATION APPROVED BY

Dr. Wm. G. Helfrich

William Helfrich D.

OR ASST. MEDICAL EXAMINER

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture of 2nd, 3rd, and 4th metatarsal bones, right
Arteriosclerotic Cardio Vascular Disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER- LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Windsor Rest Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3025 Windsor Ave., Baltimore, Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

7-29-1950

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

A heavy brass gas heater fell over on the top of patient's left foot

22. I hereby certify that I attended the deceased from 8-1, 1950, to 8-12, 1950, that I last saw the deceased alive on 8-12, 1950, and that death occurred at 9:00 P. M., from the causes and on the date stated above.

23A. SIGNATURE

J. E. Egan

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/18/50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Balto Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 17 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm Cook Inc. 1217 St. Paul St

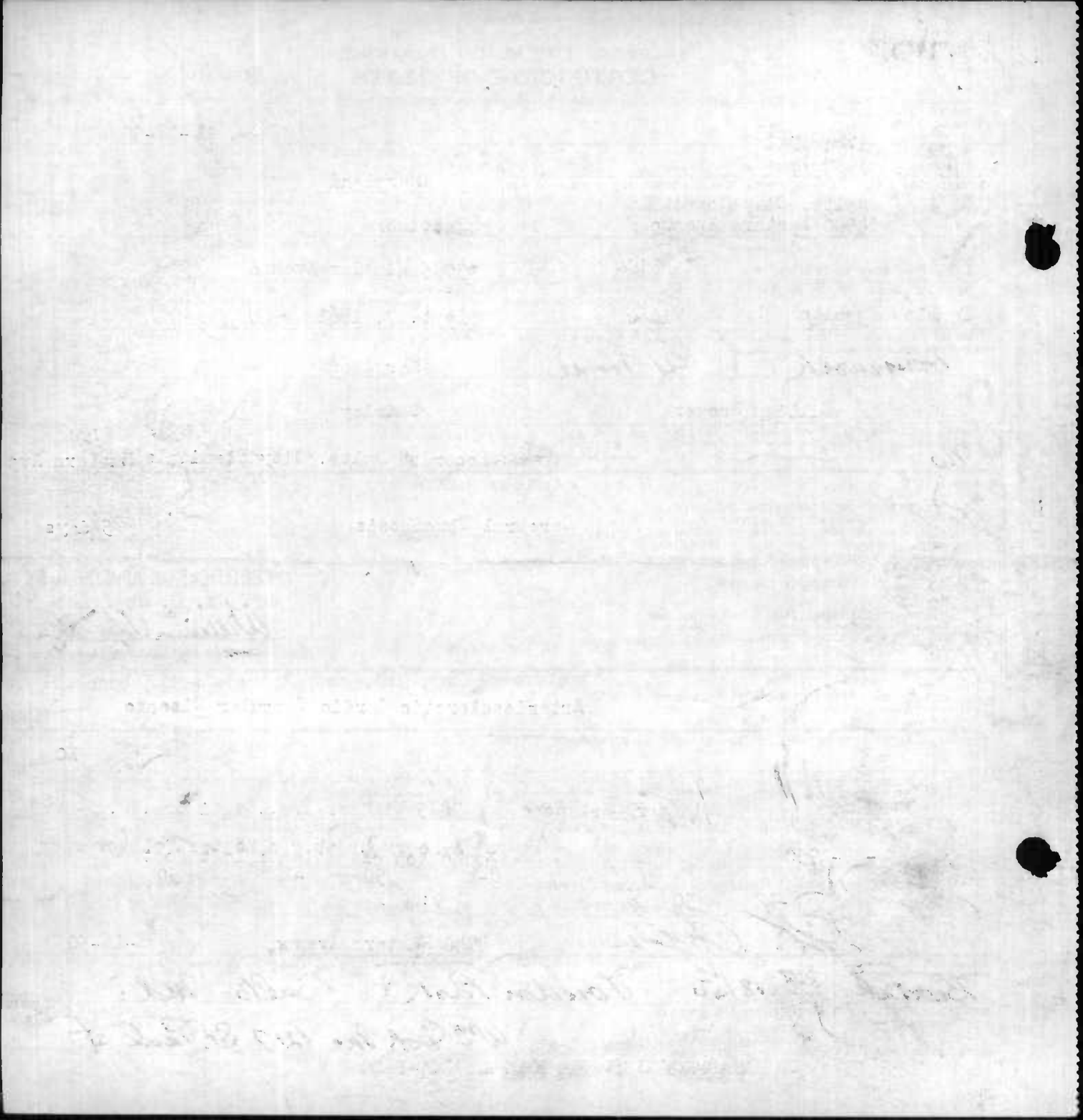
VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER

83B

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7108

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT STEINITZ

2. DATE
OF
DEATH

Aug 16 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md

B. COUNTY

Anne Arundel

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Sinai Hospital, Baltimore

C. CITY OR TOWN

Balto

Rural

(If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

8216 Wilson Ave 5300

5. SEX

m

6. COLOR OR RACE

w

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

m

8. DATE OF BIRTH

5/26/1905

9. AGE (In years
last birthday)

45

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR
INDUSTRY

Wm E. Hooper & Sons

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Oscar Steinitz Sr.

14. MOTHER'S MAIDEN NAME

Pauline Leidiger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Hazel W. Steinitz

ADDRESS

18.

591X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Pulmonary edema
Renal insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Subacute Glomerulo-
nephritis

(C)

INTERVAL BETWEEN
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 16, 1950, to August 16, 1950, that I last saw the deceased alive on August 16, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Frank Winter

23B. ADDRESS

Sinai Hospital, Baltimore, August 16 50

23C. DATE SIGNED

August 16 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/19/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 17 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

10th Cook Inc. 1217 St. Paul st

ADDRESS

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1912.

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1911.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1912.

THE COMMISSIONER OF THE LAND OFFICE
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF
THE FOLLOWING:

THE STATE OF NEW YORK
JANUARY 10, 1912.

TO THE COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1911.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
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THE STATE OF NEW YORK
JANUARY 10, 1912.

TO THE COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1911.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1912.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7109
Registered No. 50 7109

BIRTH NO. 50-16843

| | | | |
|--|--|--|------------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| Baby Fowlkes | | August 9, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| 6. Length of stay in Baltimore | | D. STREET ADDRESS (If rural, give location) 516 North Eden Street | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH August 9, 1950 |
| 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME James Keith | | 14. MOTHER'S MAIDEN NAME Hattie Fowlkes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. INFORMANT ADDRESS Hospital Records | |
| 16. SOCIAL SECURITY NO. | | | |

| | | |
|--|--|---|
| 18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Prematurity | | INTERVAL BETWEEN ONSET AND DEATH 5 min. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION 2 | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 19B. MAJOR FINDINGS OF OPERATION | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from August 9, 1950, to August 9, 1950 that I last saw the deceased alive on August 9, 1950, and that death occurred at 3:30 Pm., from the causes and on the date stated above. | | |
| 23A. SIGNATURE Bruce A. Harris | | 23B. ADDRESS 601 North Broadway |
| 23C. DATE SIGNED 8-11-50 | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY Hos. Beyond |
| 24D. LOCATION (City, town, or county) (State) | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1950 | | 25. FUNERAL DIRECTOR ADDRESS Huntington Williams, M.D. |

CERTIFICATE OF DEATH

| | | | | | | | |
|----------------------------------|--|---------------------------------|--|---------------------------------|--|----------------------------------|--|
| <p>1. Name of deceased</p> | | <p>2. Sex</p> | | <p>3. Age</p> | | <p>4. Date of death</p> | |
| <p>5. Place of death</p> | | <p>6. Cause of death</p> | | <p>7. Manner of death</p> | | <p>8. Signature of physician</p> | |
| <p>9. Signature of registrar</p> | | <p>10. Signature of witness</p> | | <p>11. Signature of witness</p> | | <p>12. Signature of witness</p> | |
| <p>13. Signature of witness</p> | | <p>14. Signature of witness</p> | | <p>15. Signature of witness</p> | | <p>16. Signature of witness</p> | |
| <p>17. Signature of witness</p> | | <p>18. Signature of witness</p> | | <p>19. Signature of witness</p> | | <p>20. Signature of witness</p> | |
| <p>21. Signature of witness</p> | | <p>22. Signature of witness</p> | | <p>23. Signature of witness</p> | | <p>24. Signature of witness</p> | |
| <p>25. Signature of witness</p> | | <p>26. Signature of witness</p> | | <p>27. Signature of witness</p> | | <p>28. Signature of witness</p> | |
| <p>29. Signature of witness</p> | | <p>30. Signature of witness</p> | | <p>31. Signature of witness</p> | | <p>32. Signature of witness</p> | |
| <p>33. Signature of witness</p> | | <p>34. Signature of witness</p> | | <p>35. Signature of witness</p> | | <p>36. Signature of witness</p> | |
| <p>37. Signature of witness</p> | | <p>38. Signature of witness</p> | | <p>39. Signature of witness</p> | | <p>40. Signature of witness</p> | |
| <p>41. Signature of witness</p> | | <p>42. Signature of witness</p> | | <p>43. Signature of witness</p> | | <p>44. Signature of witness</p> | |
| <p>45. Signature of witness</p> | | <p>46. Signature of witness</p> | | <p>47. Signature of witness</p> | | <p>48. Signature of witness</p> | |
| <p>49. Signature of witness</p> | | <p>50. Signature of witness</p> | | <p>51. Signature of witness</p> | | <p>52. Signature of witness</p> | |
| <p>53. Signature of witness</p> | | <p>54. Signature of witness</p> | | <p>55. Signature of witness</p> | | <p>56. Signature of witness</p> | |
| <p>57. Signature of witness</p> | | <p>58. Signature of witness</p> | | <p>59. Signature of witness</p> | | <p>60. Signature of witness</p> | |
| <p>61. Signature of witness</p> | | <p>62. Signature of witness</p> | | <p>63. Signature of witness</p> | | <p>64. Signature of witness</p> | |
| <p>65. Signature of witness</p> | | <p>66. Signature of witness</p> | | <p>67. Signature of witness</p> | | <p>68. Signature of witness</p> | |
| <p>69. Signature of witness</p> | | <p>70. Signature of witness</p> | | <p>71. Signature of witness</p> | | <p>72. Signature of witness</p> | |
| <p>73. Signature of witness</p> | | <p>74. Signature of witness</p> | | <p>75. Signature of witness</p> | | <p>76. Signature of witness</p> | |
| <p>77. Signature of witness</p> | | <p>78. Signature of witness</p> | | <p>79. Signature of witness</p> | | <p>80. Signature of witness</p> | |
| <p>81. Signature of witness</p> | | <p>82. Signature of witness</p> | | <p>83. Signature of witness</p> | | <p>84. Signature of witness</p> | |
| <p>85. Signature of witness</p> | | <p>86. Signature of witness</p> | | <p>87. Signature of witness</p> | | <p>88. Signature of witness</p> | |
| <p>89. Signature of witness</p> | | <p>90. Signature of witness</p> | | <p>91. Signature of witness</p> | | <p>92. Signature of witness</p> | |
| <p>93. Signature of witness</p> | | <p>94. Signature of witness</p> | | <p>95. Signature of witness</p> | | <p>96. Signature of witness</p> | |
| <p>97. Signature of witness</p> | | <p>98. Signature of witness</p> | | <p>99. Signature of witness</p> | | <p>100. Signature of witness</p> | |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7110
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Clarence E. Mixer

2. DATE
OF
DEATH

Aug 14 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR
INSTITUTION

Union Memorial Hosp.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

807 Powers St

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 8 1909

9. AGE (In years
last birthday)

41

If Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Changew

10B. KIND OF BUSINESS OR
INDUSTRY

Yellow Cox

11. BIRTH PLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. H. Mixer

14. MOTHER'S MAIDEN NAME

Eva Sweitzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.
212-070-801

17. INFORMANT

ADDRESS

Ngumi A. Mixer 807 Powers St.

18. *420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Immediate

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from *19 Oct*, 1949, to *26 Jun*, 1950, that I last saw the
deceased alive on *13 Aug*, 1950, and that death occurred at *6 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

John B. Brown

23B. ADDRESS

5602 Harford Rd

23C. DATE SIGNED

15 Aug 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Aug 17/50

meadowridge

Wash. Blvd. Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 17 1950

Huntington Williams, Md

Justin E. Donovan - 3818 Roland

VS 150

68254

94a

CERTIFICATE OF DEATH

1. Name of deceased John Doe
2. Date of death 10/10/1910
3. Place of death at home
4. Cause of death old age
5. Age of deceased 78
6. Sex of deceased male
7. Occupation of deceased farmer
8. Name of informant John Doe
9. Name of physician Dr. J. H. Smith
10. Name of registrar John Doe

11. Name of funeral home John Doe
12. Name of cemetery John Doe
13. Name of burial place John Doe
14. Name of interment place John Doe
15. Name of place of burial John Doe

16. Name of place of interment John Doe
17. Name of place of burial John Doe
18. Name of place of interment John Doe
19. Name of place of burial John Doe
20. Name of place of interment John Doe

21. Name of place of burial John Doe
22. Name of place of interment John Doe
23. Name of place of burial John Doe
24. Name of place of interment John Doe
25. Name of place of burial John Doe

26. Name of place of interment John Doe
27. Name of place of burial John Doe
28. Name of place of interment John Doe
29. Name of place of burial John Doe
30. Name of place of interment John Doe

31. Name of place of burial John Doe
32. Name of place of interment John Doe
33. Name of place of burial John Doe
34. Name of place of interment John Doe
35. Name of place of burial John Doe

36. Name of place of interment John Doe
37. Name of place of burial John Doe
38. Name of place of interment John Doe
39. Name of place of burial John Doe
40. Name of place of interment John Doe

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7111

BIRTH NO. 163

1. NAME OF DECEASED
(Type or Print)

Edgar Russell McCellan Robertson

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

Carroll

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

New Windsor

D. STREET ADDRESS (If rural, give location)

Route #1

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan 30 1931

9. AGE (In years last birthday)

19

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Road construction

11. BIRTHPLACE (State or foreign country)

Carroll Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John Robertson

14. MOTHER'S MAIDEN NAME

Mary Mc. Celland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Bulah Robertson, Westminster, Md.

18. **E 976 X I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Gunshot wound of chest**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

R.F.D. #1, New Windsor, Carroll Co.

Maryland

21D. TIME (Month) (Day) (Year) OF INJURY

August 16, 1950 6:30 A.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley A. Dunsacker, M.D.

23B. CHIEF MEDICAL EXAMINER.....☐

ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

August 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 20-50

24C. NAME OF CEMETERY OR CREMATORY

Stone Chapel

24D. LOCATION (City, town, or county)

Carroll Co

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, Md.

25. FUNERAL DIRECTOR

ADDRESS

H. Bankard, Son Westminster Md.

AUG 17 1950

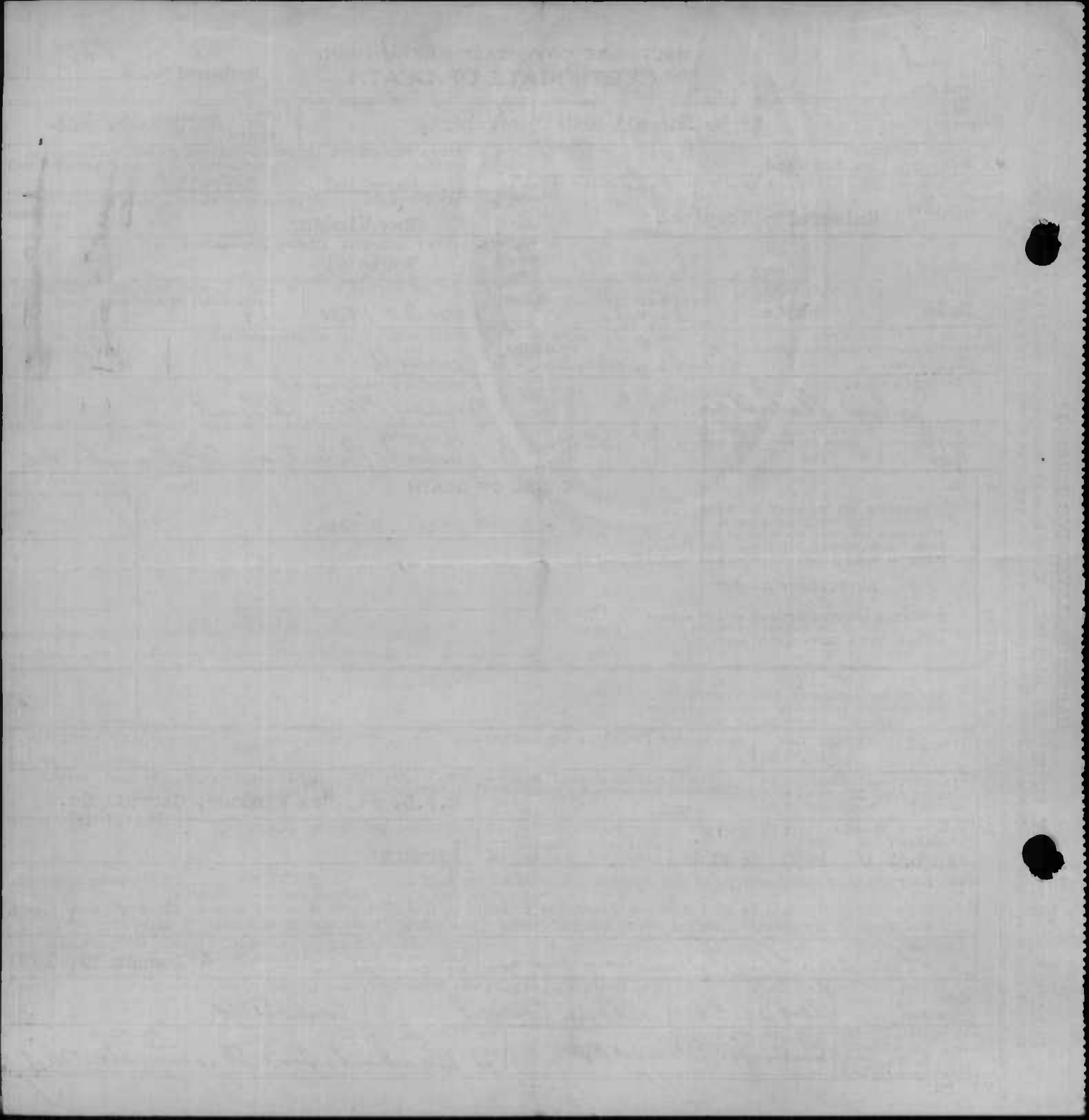
V-8624

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164c ✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7112

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Columbia L. Jenkins

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2101 W. Caldspring Lane

CITY OR TOWN

Baltimore

O. STREET ADDRESS (If rural, give location)

1826 Madison Avenue

C. Length of stay in Baltimore

50

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 15, 1880

9. AGE (in years last birthday)

70

10. Under 1 Year

3

11. Under 24 Hours

1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dress maker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Downing

14. MOTHER'S MAIDEN NAME

Georgianna Downing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

lent.

17. INFORMANT

ADDRESS

Mrs. F. Rye - 2455 McCulloch St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of ovary

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Metastasis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1950, to August 16, 1950, that I last saw the deceased alive on Aug. 14, 1950 and that death occurred at 7 P. m., from the causes and on the date stated above.

23A. SIGNATURE

M. T. Lachman

23B. ADDRESS

600 N. Arlington Ave.

23C. DATE SIGNED

8-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 19-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Balt.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

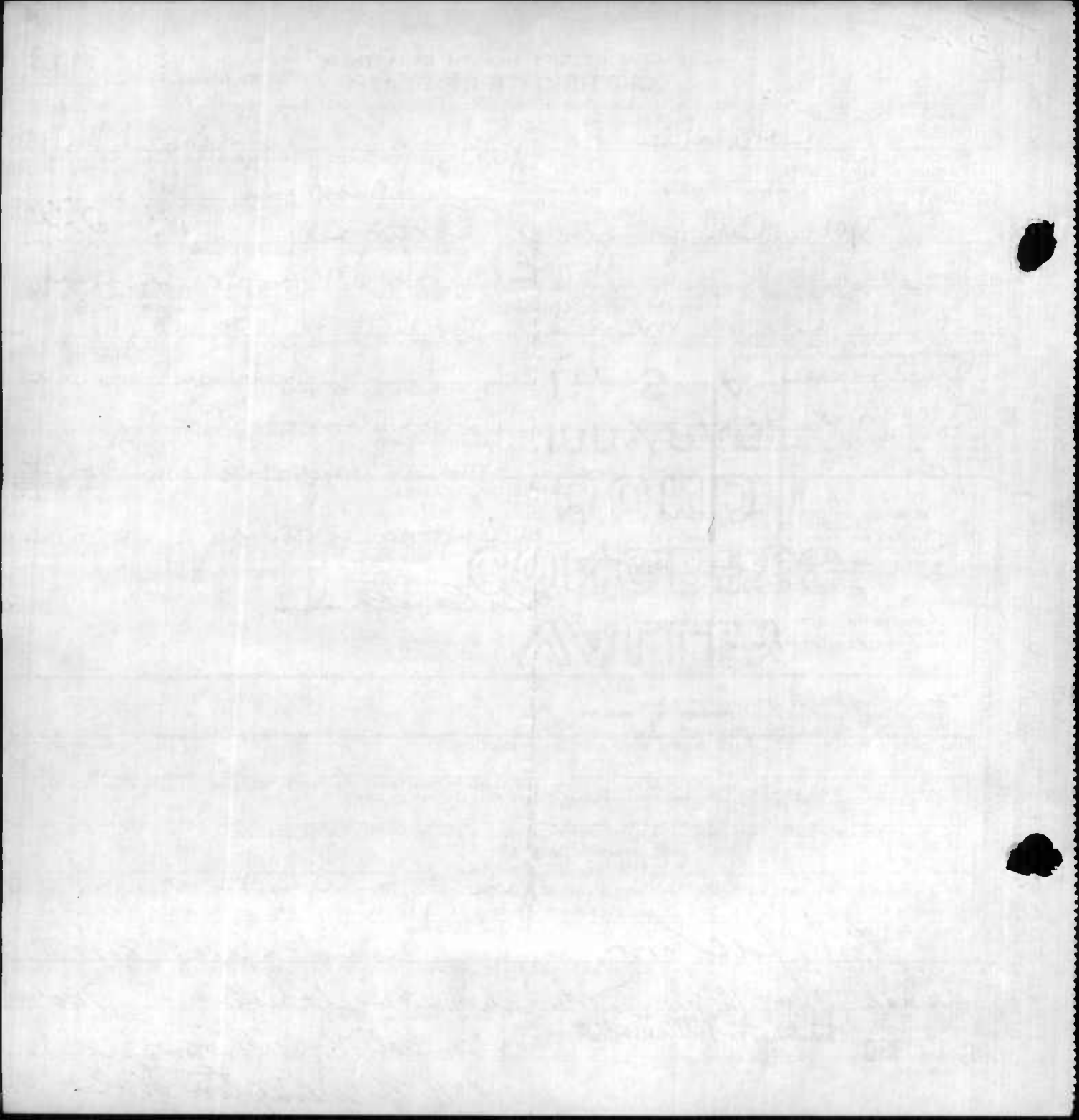
ADDRESS

Samuel W. Sullivan Jr.

AUG 17 1950

VS 150

1011 N. Arlington Ave 49a



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7113

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Carolyn

Hudson

2. DATE
OF
DEATH

AUG 16 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Severna Park

D. STREET ADDRESS (If rural, give location)

5200

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Johnnie Hudson

14. MOTHER'S MAIDEN NAME

Marion Pack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

204.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute Lymphatic Leukemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 19 to 8-16-1950 that I last saw the deceased alive on 8-16-1950 and that death occurred at 3:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Gustafson M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 17 1950

REGISTRAR'S SIGNATURE

Antington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

J.B. Johnson Annapolis, Md

8-16-20

Robert E. Johnson

Robert E. Johnson

Robert E. Johnson

Robert E. Johnson

Robert E. Johnson

Robert E. Johnson

Robert E. Johnson

Robert E. Johnson

Robert E. Johnson

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7114
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY Sarah Mackin

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1609 Holbrook Street

B. FULL NAME OF HOSPITAL OR INSTITUTION

7609 Holbrook Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Dec 25, 1872

9. AGE (In years last birthday)

77

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Daniel McKay

14. MOTHER'S MAIDEN NAME

Mary Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Francis M. Mackin, 1104 E. Biddle Street

18.

331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerosis (Cerebral)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension

(C)

Acute Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8/16 1950 to 8/16 1950 that I last saw the deceased alive on 8/16 1950 and that death occurred at 1 P. M., from the causes and on the date stated above.

23A. SIGNATURE

A. H. Hornstein

23B. ADDRESS

204 E. Biddle St

23C. DATE SIGNED

8/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county) (State)

Baltimore

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc.

1217 St. Paul Street

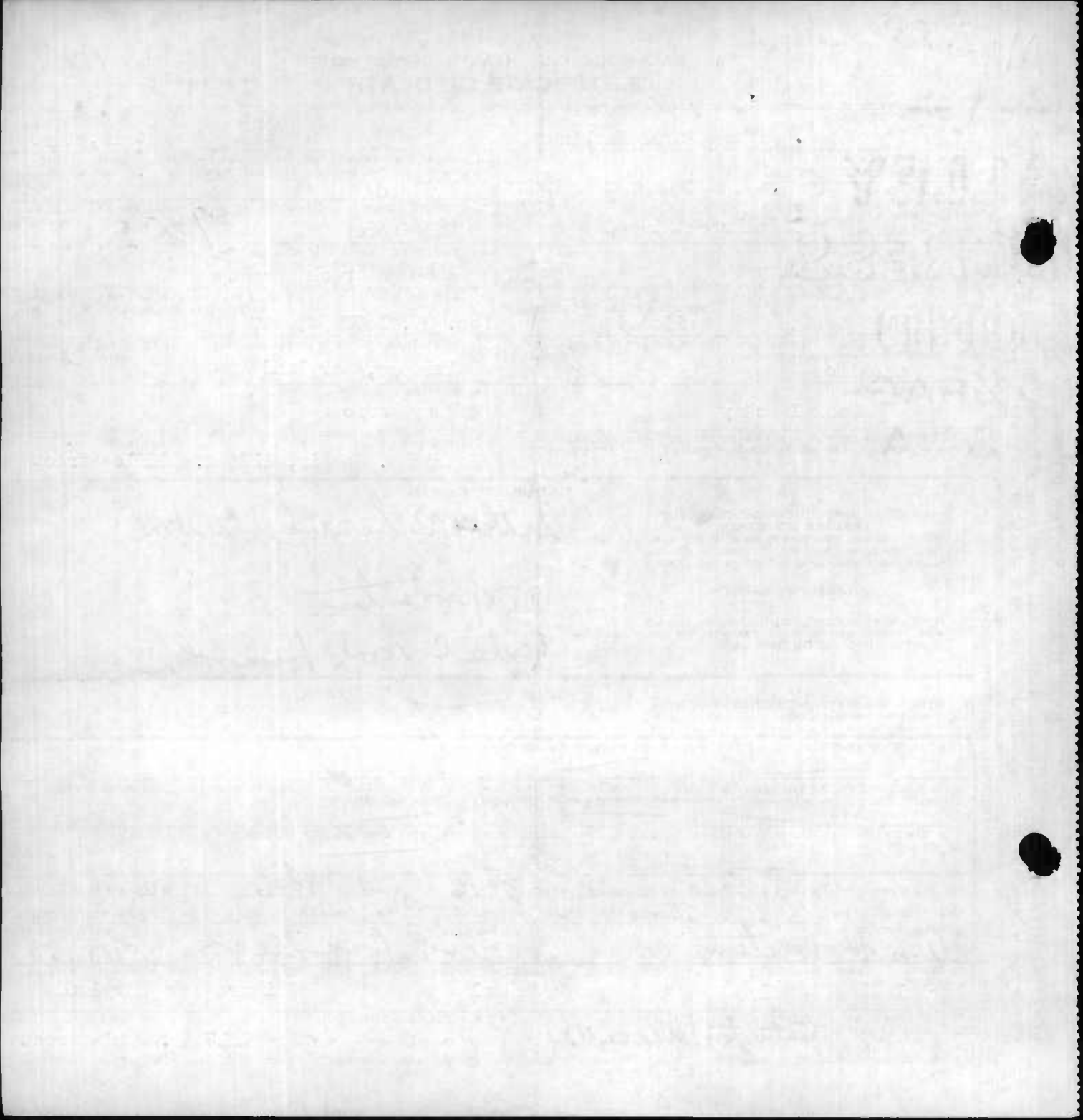
AUG 17 1950

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7115
Registered No.

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Sidney Diller Whelpley</u> | | 2. DATE OF DEATH <u>August 15, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> | | B. COUNTY <u>12-05</u> | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>231 E. Lafayette Avenue</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> | | D. STREET ADDRESS (If rural, give location) <u>231 E. Lafayette Avenue</u> | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | | 8. DATE OF BIRTH <u>October 25, 1867</u> | | 9. AGE (In years last birthday) <u>82</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Armature - grinder</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | |
| 13. FATHER'S NAME <u>Albert Whelpley</u> | | 14. MOTHER'S MAIDEN NAME <u>Abby Wardell</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>212-16-2143</u> | | 17. INFORMANT ADDRESS <u>Mrs. Anna J. Whelpley, 231 E. Lafayette</u> | |
| 18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Vascular Accident</u> DUE TO <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO DUE TO | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>August 5, 1950</u> to <u>Aug. 15</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Aug. 16</u> , 19 <u>50</u> , and that death occurred at <u>4:00 P. m.</u> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. ADDRESS <u>2058 Hanford Rd.</u> | | 23C. DATE SIGNED <u>Aug. 17, 1950</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>8/17/50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u> | |
| 24D. LOCATION (City, town, or county) <u>Dorsey</u> | | 24E. STATE <u>Maryland</u> | | 25. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook, Inc. 1217 St. Paul Street</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 17 1950</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook, Inc. 1217 St. Paul Street</u> | |

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7116
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) **Cooney**

Caldwell

2. DATE OF DEATH **8/16/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Baltimore, City**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1032 Sharp Street

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE **Maryland**
B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, City.

D. STREET ADDRESS (If rural, give location)
1032 Sharp Street

c. Length of stay in Baltimore **40 Yrs**

Yrs.
Mos.
Days

5. SEX **M**

6. COLOR OR RACE **C**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **W**

8. DATE OF BIRTH **1876**

9. AGE (In years last birthday) **74**

If Under 1 Year Months Days
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer

10B. KIND OF BUSINESS OR INDUSTRY
B and O, R.R.CO

11. BIRTHPLACE (State or foreign country)
South Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Celie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or uokooow) **No**

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
George Caldwell-1032 Sharp Street

18. **331X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Coronary Hemorrhage**

4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Hypertension**

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **October 14, 1949**, to **August 15, 1950**, that I last saw the deceased alive on **8-15**, 1950, and that death occurred at **2:00 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

Benjamin M. D.

23B. ADDRESS

884 Sharp St.

23C. DATE SIGNED

8-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

8/19/50

24C. NAME OF CEMETERY OR CREMATORY

Mount Calvary Ct.

24D. LOCATION (City, town, or county) (State)

A.A.Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 17 1950

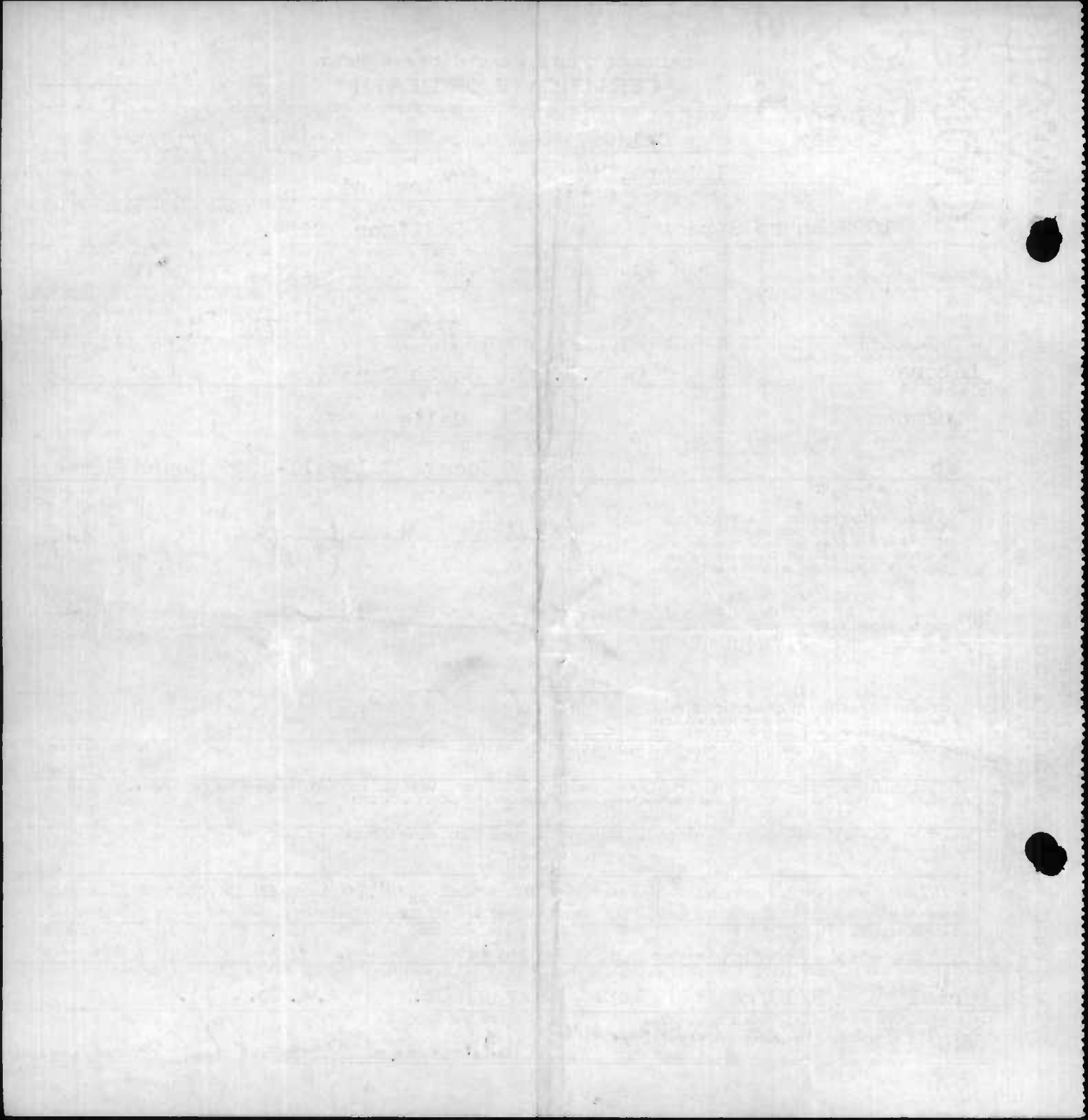
REGISTRAR'S SIGNATURE

Montgomery

25. FUNERAL DIRECTOR

108-W General L. Brown & Son - Montgomery

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY VIRGINIA LELAND

2. DATE
OF
DEATH

Aug 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital of Md.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

A. A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Annapolis

D. STREET ADDRESS (If rural, give location)

R. F. D.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 13, 1874

9. AGE (In years
last birthday)

75

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William J. Stewart

14. MOTHER'S MAIDEN NAME

? Ashmeade

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Howard Palmer Randallstown, Md.

18.

331.X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cerebral-vascular Hemorrhage

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

Hypertension

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK

22. I hereby certify that I attended the deceased from Aug. 7, 1950, to Aug. 17, 1950, that I last saw the deceased alive on Aug. 17, 1950, and that death occurred at 5:25 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

8/19/50

Glen Haven Mem. Pk.

Glenburnie, Md.

DATE RECEIVED BY
LOCAL REGISTRAR
AUG 17 1950

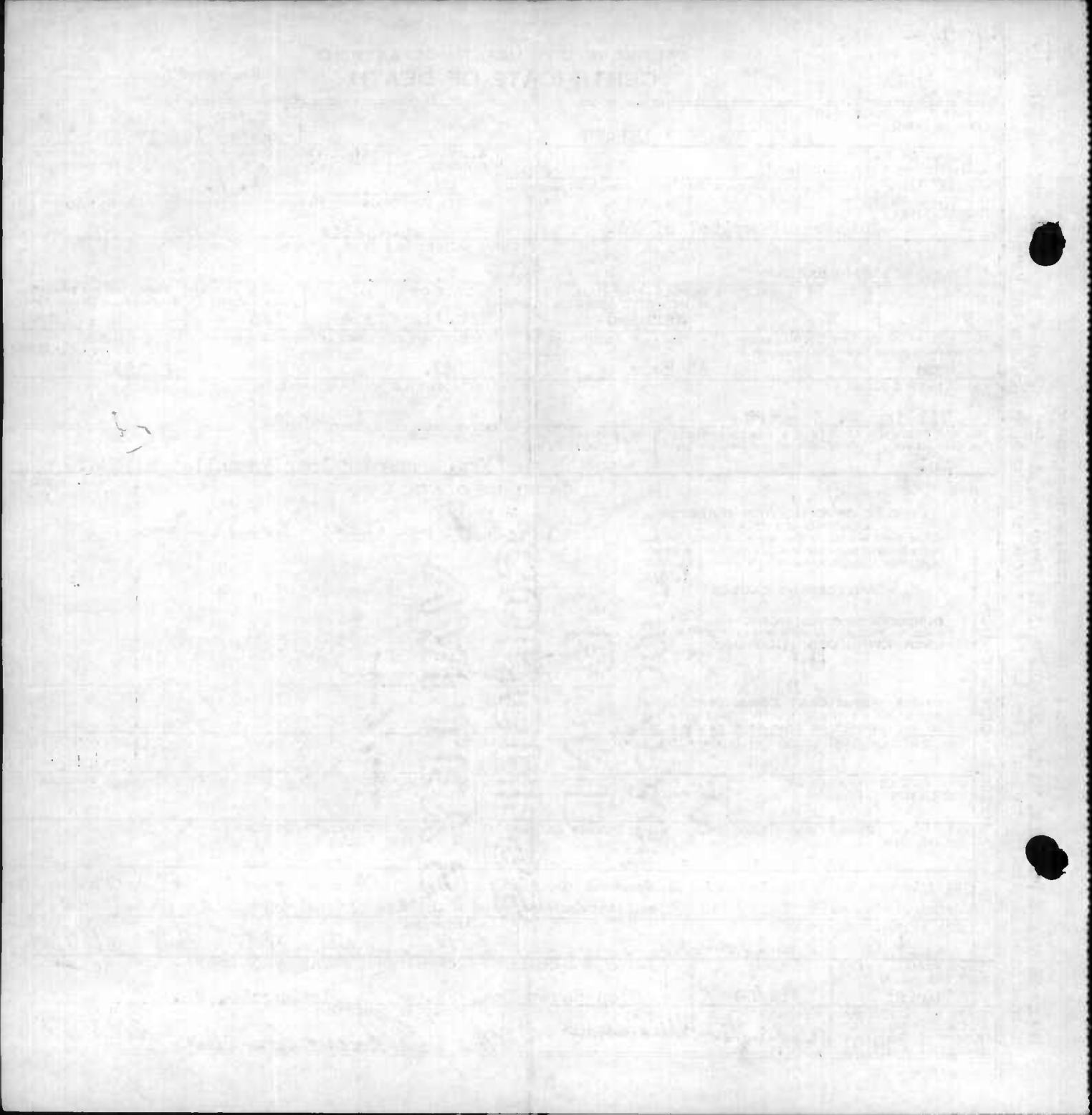
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Thurston Williams, Md.

Wm. J. Pickner & Son, Inc. Balt. Md.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7118

BIRTH NO. 536 7118

| | | | | | |
|---|------------------------------|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) <i>Lester R. Snyder</i> (Rexford) | | | 2. DATE OF DEATH <i>8-16-50</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>38 University Hospital</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> | | |
| c. Length of stay in Baltimore Yrs. <i>38</i> Mos. <i>5200</i> Days | | | D. STREET ADDRESS (If rural, give location) <i>3600 Croyden Rd.</i> | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>July 8, 1902</i> | 9. AGE (In years; last birthday) <i>48</i> | 10. Under 1 Year: Months <i>48</i> Days <i>48</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Branch Manager</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Nat'l Radiator Co.</i> | | |
| 11. BIRTHPLACE (State or foreign country) <i>? Md.</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>Charley Snyder</i> | | | 14. MOTHER'S MAIDEN NAME <i>Alice M. Cox</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>215-10-9013</i> | | |
| 17. INFORMANT <i>Mrs. A. A. Bernice Snyder</i> | | | ADDRESS <i>3600 Croyden Rd.</i> | | |

18. *446 X*
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) *Essential hypertension*
DUE TO

(B) *Nephritis*
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

| | | | | | |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <i>7-16-50</i> | | 19B. MAJOR FINDINGS OF OPERATION <i>Smithwick procedure</i> | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>8-16</i> 19 <i>50</i> , to <i>8-16</i> 19 <i>50</i> , that I last saw the deceased alive on <i>8-16</i> 19 <i>50</i> , and that death occurred at <i>6:00</i> m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Thomas R. Smithwick</i> M.D. | | 23B. ADDRESS <i>Univ. Hosp.</i> | | 23C. DATE SIGNED <i>8-18-50</i> | |

| | | | |
|--|--|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>8/19/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i> | 24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 17 1950</i> | REGISTRAR'S SIGNATURE <i>Wm. J. Jackson</i> | 25. FUNERAL DIRECTOR <i>Wm. J. Jackson & Son Inc.</i> | |
| | | ADDRESS <i>Bell Md</i> | |

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7119

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WALTER

C.

VAIL

2. DATE
OF
DEATH

August 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Anne Arundel

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Altamont Hotel, Eutaw & Lanvale Sts

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Princess Anne Md.

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar. 30, 1914

9. AGE (In years
last birthday)

36

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physician

10B. KIND OF BUSINESS OR INDUSTRY

Professional

11. BIRTHPLACE (State or foreign country)

Cortland N. Y.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Harrison Vail

14. MOTHER'S MAIDEN NAME

Anna Chaplin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World #2

16. SOCIAL
SECURITY NO.
None

17. INFORMANT

ADDRESS

Mrs. Jane Z. Vail Princess Anne Md.

18. E 9702

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Barbiturate poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)
Hotel21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Altamont Hotel, Eutaw & Lanvale Streets

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
August 13, 1950

? P.m.

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingestion of "Barbivis" pills

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

M.D.

MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

8-16-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Removal

24B. DATE

8/18/50

24C. NAME OF CEMETERY OR CREMATORY

Sugar Tree

24D. LOCATION (City, town, or county)

Wilmington, Ohio

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Trustington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tucker & Son Inc. Balt. Md.

AUG 17 1950

N-9710

07580

163B

DECLARATION OF DEATH

Section 1

| | | | |
|---------------------|--|--------------------|--|
| 1. Name of deceased | | 2. Date of death | |
| 3. Place of death | | 4. Cause of death | |
| 5. Age at death | | 6. Sex | |
| 7. Race | | 8. Marital status | |
| 9. Occupation | | 10. Education | |
| 11. Date of birth | | 12. Date of death | |
| 13. Place of birth | | 14. Place of death | |
| 15. Cause of death | | 16. Date of death | |
| 17. Place of death | | 18. Cause of death | |
| 19. Date of death | | 20. Place of death | |
| 21. Cause of death | | 22. Date of death | |
| 23. Place of death | | 24. Cause of death | |
| 25. Date of death | | 26. Place of death | |
| 27. Cause of death | | 28. Date of death | |
| 29. Place of death | | 30. Cause of death | |
| 31. Date of death | | 32. Place of death | |
| 33. Cause of death | | 34. Date of death | |
| 35. Place of death | | 36. Cause of death | |
| 37. Date of death | | 38. Place of death | |
| 39. Cause of death | | 40. Date of death | |
| 41. Place of death | | 42. Cause of death | |
| 43. Date of death | | 44. Place of death | |
| 45. Cause of death | | 46. Date of death | |
| 47. Place of death | | 48. Cause of death | |
| 49. Date of death | | 50. Place of death | |
| 51. Cause of death | | 52. Date of death | |
| 53. Place of death | | 54. Cause of death | |
| 55. Date of death | | 56. Place of death | |
| 57. Cause of death | | 58. Date of death | |
| 59. Place of death | | 60. Cause of death | |
| 61. Date of death | | 62. Place of death | |
| 63. Cause of death | | 64. Date of death | |
| 65. Place of death | | 66. Cause of death | |
| 67. Date of death | | 68. Place of death | |
| 69. Cause of death | | 70. Date of death | |
| 71. Place of death | | 72. Cause of death | |
| 73. Date of death | | 74. Place of death | |
| 75. Cause of death | | 76. Date of death | |
| 77. Place of death | | 78. Cause of death | |
| 79. Date of death | | 80. Place of death | |
| 81. Cause of death | | 82. Date of death | |
| 83. Place of death | | 84. Cause of death | |
| 85. Date of death | | 86. Place of death | |
| 87. Cause of death | | 88. Date of death | |
| 89. Place of death | | 90. Cause of death | |
| 91. Date of death | | 92. Place of death | |
| 93. Cause of death | | 94. Date of death | |
| 95. Place of death | | 96. Cause of death | |
| 97. Date of death | | 98. Place of death | |
| 99. Cause of death | | 100. Date of death | |

| | | | |
|---------------------|--|--------------------|--|
| 1. Name of deceased | | 2. Date of death | |
| 3. Place of death | | 4. Cause of death | |
| 5. Age at death | | 6. Sex | |
| 7. Race | | 8. Marital status | |
| 9. Occupation | | 10. Education | |
| 11. Date of birth | | 12. Date of death | |
| 13. Place of birth | | 14. Place of death | |
| 15. Cause of death | | 16. Date of death | |
| 17. Place of death | | 18. Cause of death | |
| 19. Date of death | | 20. Place of death | |
| 21. Cause of death | | 22. Date of death | |
| 23. Place of death | | 24. Cause of death | |
| 25. Date of death | | 26. Place of death | |
| 27. Cause of death | | 28. Date of death | |
| 29. Place of death | | 30. Cause of death | |
| 31. Date of death | | 32. Place of death | |
| 33. Cause of death | | 34. Date of death | |
| 35. Place of death | | 36. Cause of death | |
| 37. Date of death | | 38. Place of death | |
| 39. Cause of death | | 40. Date of death | |
| 41. Place of death | | 42. Cause of death | |
| 43. Date of death | | 44. Place of death | |
| 45. Cause of death | | 46. Date of death | |
| 47. Place of death | | 48. Cause of death | |
| 49. Date of death | | 50. Place of death | |
| 51. Cause of death | | 52. Date of death | |
| 53. Place of death | | 54. Cause of death | |
| 55. Date of death | | 56. Place of death | |
| 57. Cause of death | | 58. Date of death | |
| 59. Place of death | | 60. Cause of death | |
| 61. Date of death | | 62. Place of death | |
| 63. Cause of death | | 64. Date of death | |
| 65. Place of death | | 66. Cause of death | |
| 67. Date of death | | 68. Place of death | |
| 69. Cause of death | | 70. Date of death | |
| 71. Place of death | | 72. Cause of death | |
| 73. Date of death | | 74. Place of death | |
| 75. Cause of death | | 76. Date of death | |
| 77. Place of death | | 78. Cause of death | |
| 79. Date of death | | 80. Place of death | |
| 81. Cause of death | | 82. Date of death | |
| 83. Place of death | | 84. Cause of death | |
| 85. Date of death | | 86. Place of death | |
| 87. Cause of death | | 88. Date of death | |
| 89. Place of death | | 90. Cause of death | |
| 91. Date of death | | 92. Place of death | |
| 93. Cause of death | | 94. Date of death | |
| 95. Place of death | | 96. Cause of death | |
| 97. Date of death | | 98. Place of death | |
| 99. Cause of death | | 100. Date of death | |

T-6 50
50 7120
MARGIN RESERVED FOR BINDING
PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7120

| | | | | | |
|--|----------------------------|--|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mary H. Hovisler Tormey</u> | | 2. DATE OF DEATH <u>Aug. 16, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto.</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Staten's Memorial Hosp.</u> | | C. CITY OR TOWN (If outside corporate limits, write in full, and give township) <u>Balto.</u> <u>15-40</u> | | | |
| C. Length of stay in Baltimore <u>84</u> Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) <u>3411 Georges Falls Pk.</u> | | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u> | | 8. DATE OF BIRTH <u>—</u> | 9. AGE (In years, last birthday) <u>84 Y.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosp.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>J. Stanislaus Hovisler</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Mc Cann</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no.</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mrs. George Tormey</u> | |

| | | | |
|--|--|--|----------------------------------|
| 18. <u>443 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| | (A) <u>HYPERTENSIVE CARDIO -</u> DUE TO <u>VASCULAR DISEASE</u> | | |
| | (B) <u>CONGESTIVE FAILURE</u> DUE TO <u>GENERALIZED ARTERIO SCLEROSIS</u> | | |
| | (C) | | |

| | | | | | |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>8/16</u> , 19 <u>50</u> , and that death occurred at <u>3:10 P.</u> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>John H. Shaw</u> M. D. | | 23B. ADDRESS <u>St. Anne Hosp.</u> | | 23C. DATE SIGNED <u>8/16/50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/19/50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery B Baltimore</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Md.</u> | | 25. FUNERAL DIRECTOR <u>H. W. Means</u> | | ADDRESS <u>805 N. Calvert St.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 18 1950</u> | | REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u> | | | |

344 George J. D.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years)
last birthdayIf Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 334X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____ on _____, 1950, to August 16, 1950, that I last saw the deceased alive on August 15, 1950, and that death occurred at 7:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 18 1950

VS 150

83a

VALLEY
CONGRESS
SECOND

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7122
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE EVANS HOLMES

2. DATE
OF
DEATH 8/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3606 Old Frederick Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-07

D. STREET ADDRESS (If rural, give location)

3606 Old Frederick Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Nov. 19, 1873

9. AGE (In years
last birthday)

76

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Silversmith

10B. KIND OF BUSINESS OR
INDUSTRYSamuel Kirk & Sons
Silversmiths

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Holmes

14. MOTHER'S MAIDEN NAME

Isabelle Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-10-2272

17. INFORMANT

ADDRESS

Mrs. Isabelle Fehn 3606 Old Frederick Rd.

18. 141X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

General Carcinomatosis

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Carcinoma of Tongue

DUE TO

1 year

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Fractured Femur (Orthopedic)

4/30/50

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 3/4 1950 to 8/14 1950, that I last saw the
deceased alive on 8/12 1950, and that death occurred at 10:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Eliot W. Johnson

M. D.

23B. ADDRESS

3432 Audubon Ave

23C. DATE SIGNED

8/17/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/18/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Pk.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tuckner & Sons Inc. Balt. Md.

AUG 18 1950

VS 150

45B

Derlacher
ME.

DENISE A. PORTER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 7123

BIRTH NO. 50-16401

1. NAME OF DECEASED
(Type or Print)

Denise A Porter

2. DATE
OF
DEATH

8-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, do or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 776X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK

NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from 8/15, 1950, to 8-17, 1950, that I last saw the deceased alive on 8-17, 1950, and that death occurred at 4:50 Am., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

On this _____ day of _____

19____

at _____

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7124

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HILMAN DUDLEY

2. DATE
OF
DEATH

Aug 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

D. O. A. - Union Memorial Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

TOWSON

D. STREET ADDRESS (If rural, give location)

8554 WILLOW OAK RD.

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

MARRIED

8. DATE OF BIRTH

Oct 15, 1899

9. AGE (In years last birthday)

50

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lab Driver

10B. KIND OF BUSINESS OR INDUSTRY

Sun Cab Co

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

J. M. Dudley

14. MOTHER'S MAIDEN NAME

Nellie Bishop

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

226-07-0084

17. INFORMANT

Mrs. Judith Dudley 8554 Willow Oak

ADDRESS

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

1 da.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease

DUE TO

1 mo.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

Dr. John R. Davis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:12 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Roman R. Freeman

23B. ADDRESS

11 W. 29th St

23C. DATE SIGNED

Aug 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/18/50

24C. NAME OF CEMETERY OR CREMATORY

Greenview

24D. LOCATION (City, town, or county)

Charlottesville, Va

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

M. G. G. 1217 St Paul St

ADDRESS

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ADELIA J. BROWN

2. DATE
OF
DEATH

Aug. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

2643 Greenmount Ave.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

2643 Greenmount Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Nov. 3, 1860

9. AGE (In years
last birthday)

89

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Easton, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas B. Coburn

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

LeRoy Brown, 2643 Greenmount Ave.

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage
apoplexy.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio-sclerosis

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan 1, 1949, to Aug 17, 1950, that I last saw the deceased alive on Aug 16, 1950 and that death occurred at 3 A. m., from the causes and on the date stated above.

23A. SIGNATURE

M. Ephraim

M. D.

23B. ADDRESS

443 E 25th St

23C. DATE SIGNED

8-17-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/19/50

24C. NAME OF CEMETERY OR CREMATORY

Spring Hill

24D. LOCATION (City, town, or county)

Easton, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

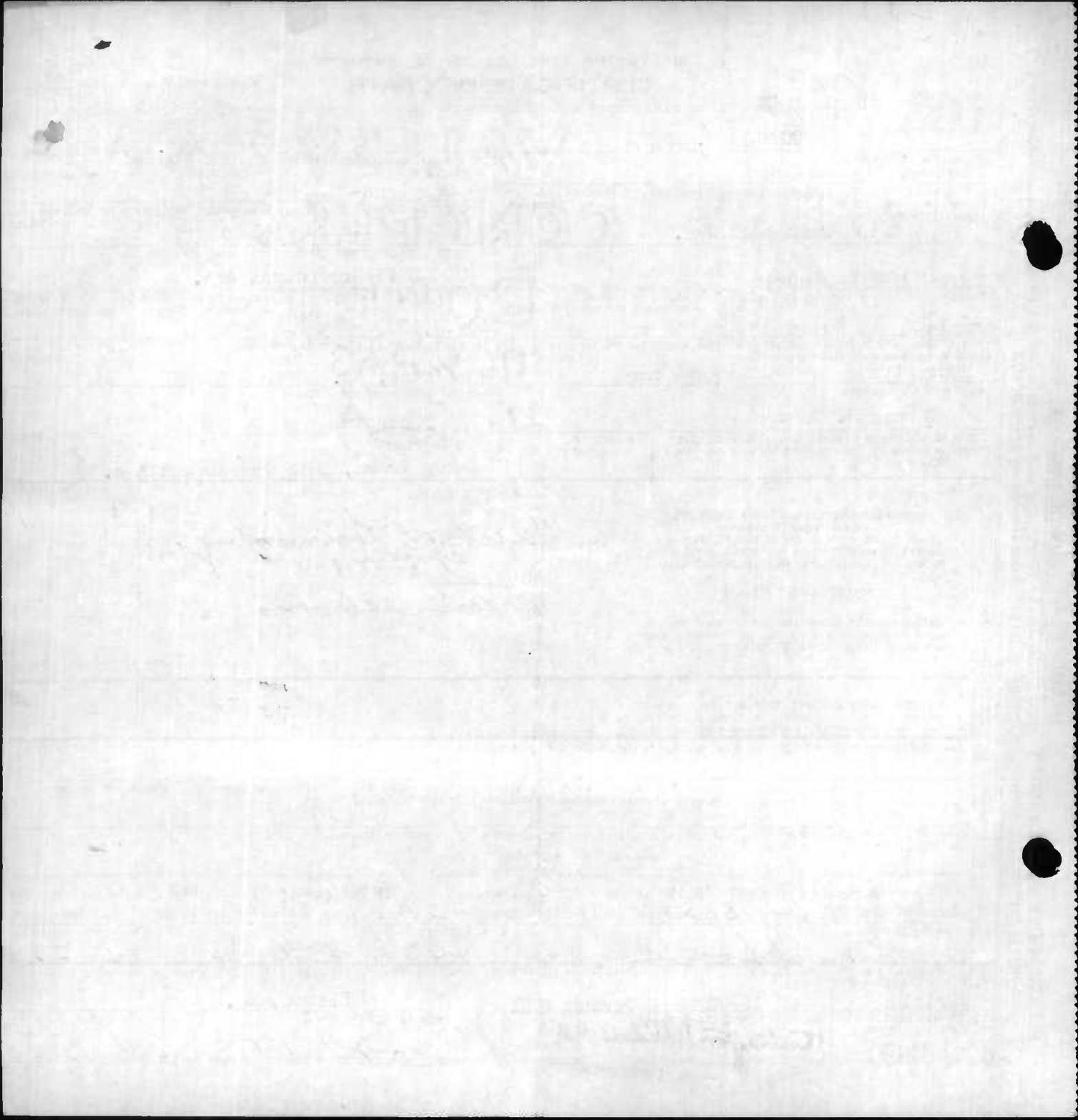
1217 St Paul St

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7126
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MORRIS VENICK

2. DATE
OF
DEATH

AUG 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1701 Ellamont Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)
A. STATE B. COUNTY

Maryland 27-17

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2518 Oakley Avenue

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 10, 1900

AGE (In years;
last birthday)

50

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Re modeling

10B. KIND OF BUSINESS OR
INDUSTRY

Furnier

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Charles Venick

14. MOTHER'S MAIDEN NAME

Minnie Sonnenborn

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS
Newben Venick-2901 Springhill Ave

18. *157X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) *Carcinomatosis, probably arising
from the pancreas*

INTERVAL BETWEEN
ONSET AND DEATH

2 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

3 yrs

19A. DATE OF OPERATION

July 27, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinomatosis

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 17, 1950*, to *Aug 17, 1950* that I last saw the
deceased alive on *Aug 17, 1950* and that death occurred at *7:45 p. m.*, from the causes and on the date stated above.

23A. SIGNATURE

Robert H. H. H.

23B. ADDRESS

1020 ST. PAUL ST.

23C. DATE SIGNED

Aug 18, 1950

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

Burial

24B. DATE

Aug 18 1950

24C. NAME OF CEMETERY OR CREMATORY

Mukro-Kodesh

24D. LOCATION (City, town, or county) (State)

Baltimore, Md

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Sal Glimson & Bros 1424 W North Ave.

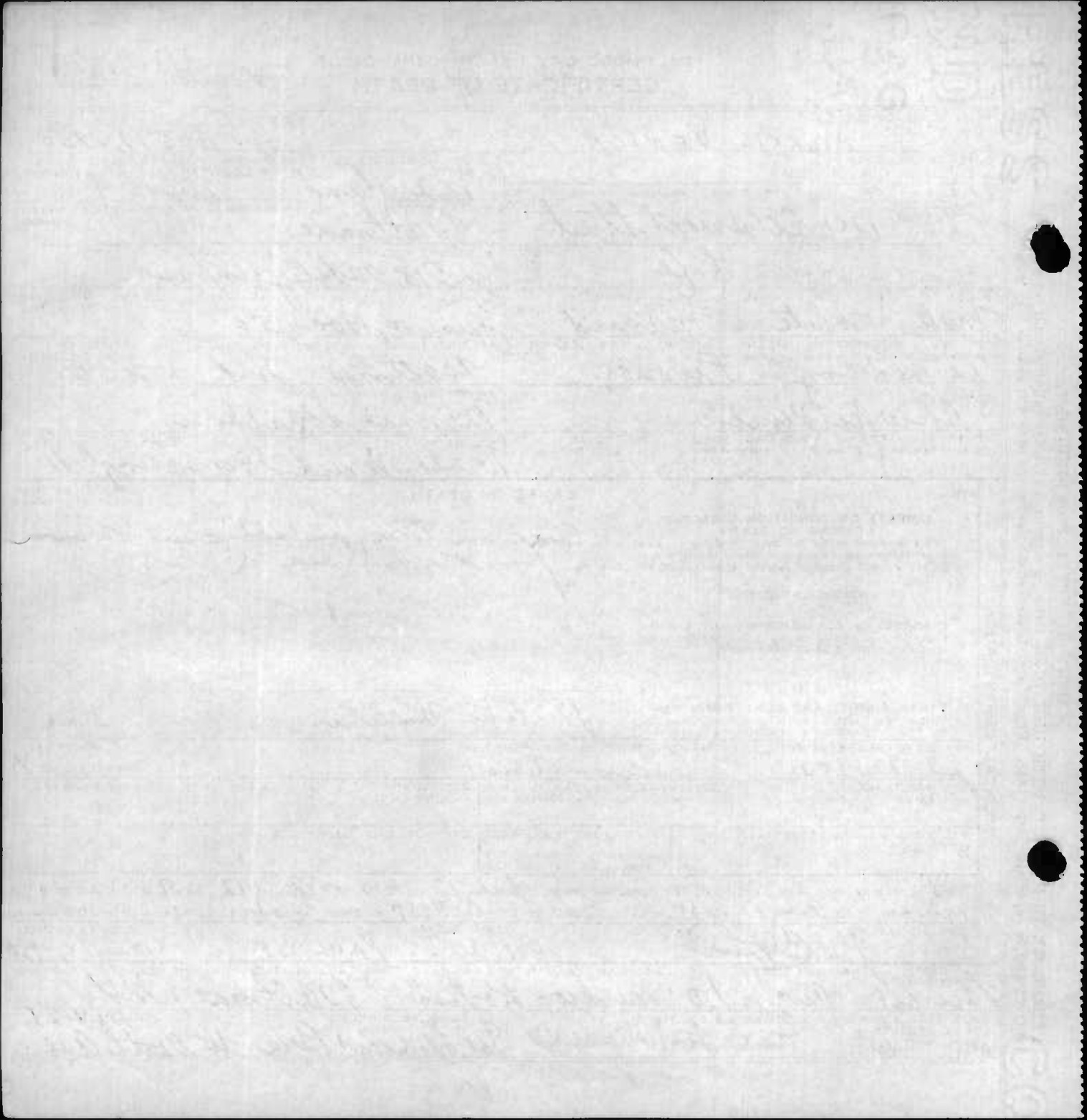
VS 150

2906E

46g

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE CORRECTED 8-25-50

REA-140688 50 7127

BALTIMORE CITY HEALTH DEPARTMENT

50 7127

CERTIFICATE OF DEATH

Registered No.

| | | | | | | | | |
|--|---------------------------|---|---|--|--|---|----------------------------------|--|
| BIRTH NO. | | | 1. NAME OF DECEASED (Type or Print) Catherine Theresa Dunn | | | 2. DATE OF DEATH August 15, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland | | | B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue | | | C. CITY OR TOWN Baltimore | | | D. STREET ADDRESS (If rural, give location) 2105 E. Baltimore Street | | |
| c. Length of stay in Baltimore Life | | | Yrs. Mos. Days | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH July 20, 1932 | | | 9. AGE (In years last birthday) 18 | 10. Under 1 Year Months: Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY none | | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME Albert Dunn | | | 14. MOTHER'S MAIDEN NAME Marie Bullerdick | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS Records: B. C. H. 4940 Eastern Avenue | | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Diabetic Acidosis DUE TO (B) Diabetes Mellitus DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 30 hrs. | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from August 15, 1950, to August 15, 1950, that I last saw the deceased alive on August 15, 1950 and that death occurred at 9:30 P.M., from the causes and on the date stated above. | | | | | | | | |
| 23A. SIGNATURE P. B. Cooper M. D. | | | 23B. ADDRESS 4940 Eastern Avenue | | | 23C. DATE SIGNED 8-16-50 | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 8-19-50 | | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel | | |
| 24D. LOCATION (City, town, or county) Baltimore Md. | | | 24E. DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1950 | | | 24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | |
| 24G. FUNERAL DIRECTOR Lilly & Zeiler, 403 S. Wolfe Street | | | 24H. ADDRESS | | | | | |

1945

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 7128**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY WODCIK

2. DATE
OF
DEATH

Aug 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE **MARYLAND**
B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION **JOHNS HOPKINS HOSPITAL**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE 26-11

c. Length of stay in Baltimore

13yrs

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

608 S. Bouldin St.

5. SEX

FEMALE

6. COLOR OR RACE

White

7. SINGLE, MARKED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

6-1-20

9. AGE (In years last birthday)

30

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Dere

14. MOTHER'S MAIDEN NAME

Mary Kuder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. **410 X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

C. Rheumatic Heart Disease

DOE TO

ANTECEDENT CAUSES

A. Pul. embolus from fibrillation

DOE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DOE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-13**, 19**50**, to **8-15**, 19**50**, that I last saw the deceased alive on **8-15**, 19**50**, and that death occurred at **m.**, from the causes and on the date stated above.

23A. SIGNATURE

A. H. Owens Jr.

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

8-19-50

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler, inc. 403 S. Wolfe Str.

VS 150

92B

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

See Document File 50-7118

EO 9-5-50

10000

10000

10000

10000

10000

10000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7129

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lillian Myers

2. DATE
OF
DEATH

8/15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Bar-Wil-Ba Convalescent Home

C. Length of stay in Baltimore

50 yrs

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

E.W. Telley 2101 W. Cold Spring

18. 334X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

M. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 4, 1950 to August 14, 1950 that I last saw the deceased alive on August 10, 1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 18 1950

VS 150

7208A

83a

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7130
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)*Mary L. DeFalco*2. DATE
OF
DEATH*Aug - 15, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

1441 Boyle St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore**24-02*

D. STREET ADDRESS (If rural, give location)

1441 Boyle St.

c. Length of stay in Baltimore

*Life*Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Widowed*

8. DATE OF BIRTH

Sept. 12, 1878

9. AGE (In years last birthday)

*71*10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Schley

14. MOTHER'S MAIDEN NAME

Mary Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Mildred E. Ross (Daughter)

ADDRESS

*Same*18. *170X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Carcinoma, left breast*INTERVAL BETWEEN
ONSET AND DEATH*? 2 1/2 yrs*

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pleural + pulmonary metastases

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 31, 1950* to *15 Aug, 1950*, that I last saw the deceased alive on *15 Aug, 1950*, and that death occurred at *7:10 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Harold P. Biehl

M.D.

23B. ADDRESS

1228 S. Charles St Baltimore

23C. DATE SIGNED

16 Aug 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1st Aug. 1950

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

24D. LOCATION (City, town, or county)

G.O. Co., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

R. Howard Evans

ADDRESS

*50**1400 S. Charles St., Balto 3 & Md*

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7131
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Marie H. Doll

2. DATE
OF
DEATH

Aug-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE *Maryland* B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

1309 PARKMAN ST.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 25-52

C. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

1309 PARKMAN ST.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

Female White

Married

Aug-14-1900

50

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Housewife

At Home

Balto. Md.

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

HERMAN OSTER

JOHANNA MIERSTECH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

No.

Herman H. Doll - Saem

18. *156.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Carcinoma of Liver*

11 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *June 8, 1948* to *August 16, 1950*, that I last saw the deceased alive on *Aug. 16, 1950* and that death occurred at *12:45 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

C. Arthur Rossberg M.D.

2411 Washington Blvd

8/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Aug 18 1950

Wilmington Williams, Md

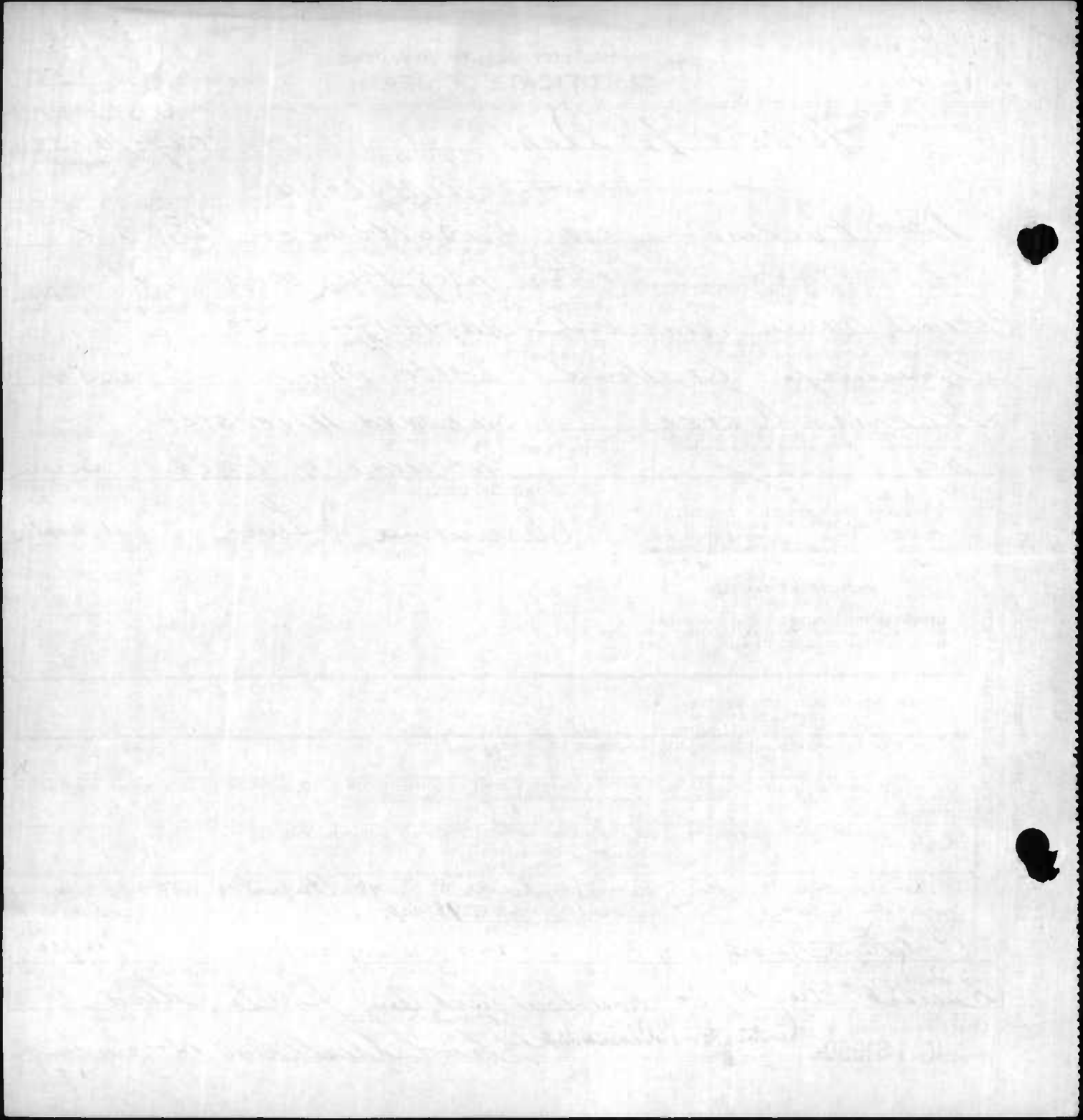
1300 E. ...

VS 150

46F-17

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7132

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LENA LORUM

2. DATE
OF
DEATH

Aug-15-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1543 Montpelier St.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1543 Montpelier St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

D. STREET ADDRESS (If rural, give location)

1543 Montpelier Street.

c. Length of stay in Baltimore

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10 Under 1 Year 11 Under 24 Hours 12 Under 24 Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Jacob Arndt

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

Ida Foley

ADDRESS

Same.

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

few minute

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

3 or 4 yrs

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension

unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/2, 1949, to 8/15, 1950, that I last saw the deceased alive on 8/8, 1950, and that death occurred at 4 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. W. Morgan

23B. ADDRESS

401 E. 25th. St. City, 18

23C. DATE SIGNED

8/17/50.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 18/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 18 1950

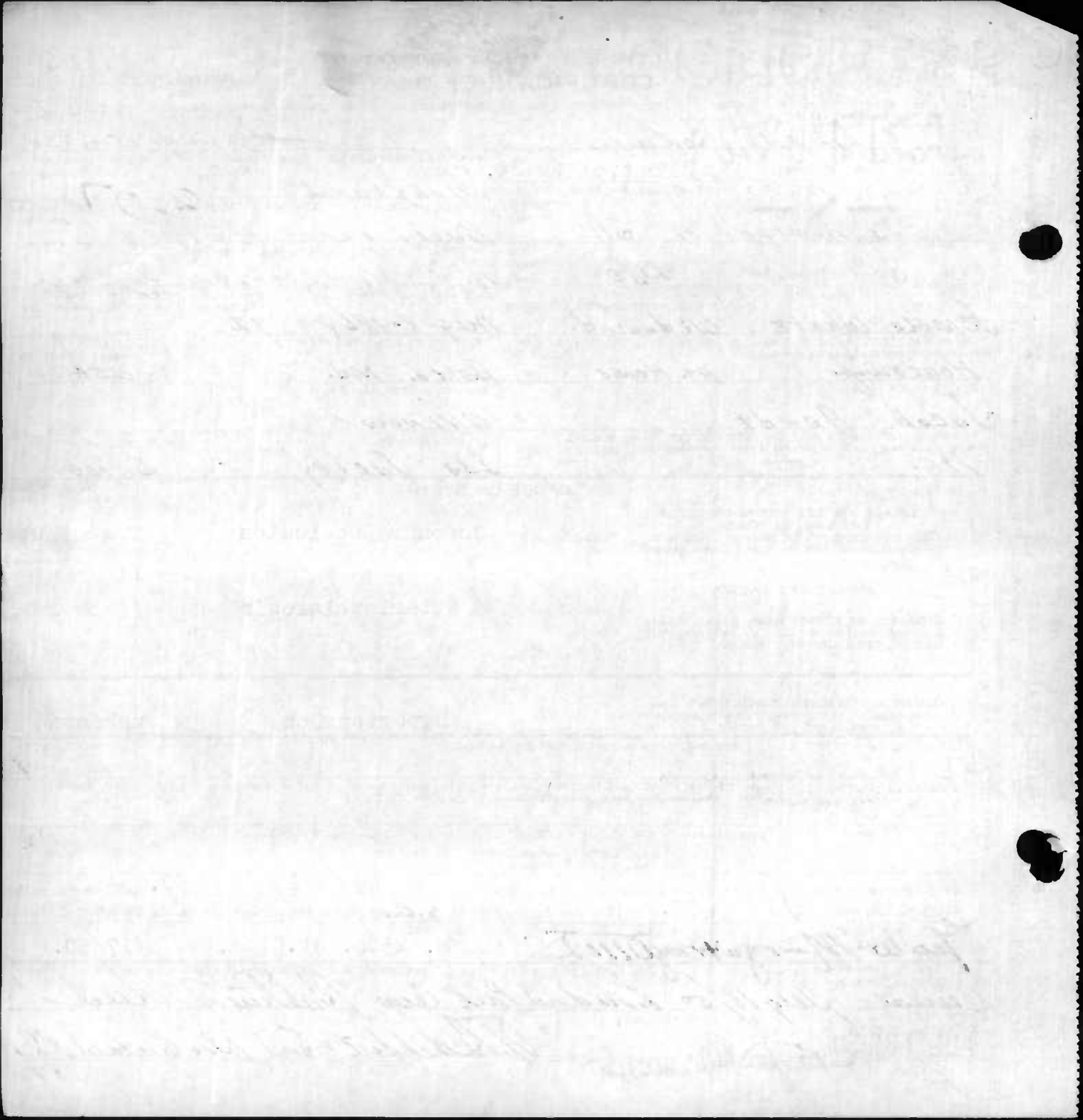
REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

J. B. McPherson & Son 1300 East Ave. R.I.

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7133

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lillie Virginia Sawyer

2. DATE

OF

DEATH

Aug-15-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution, residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

45-N-Catherine St.

C. CITY OR TOWN (If outside corporate limits, write R.U.M. and give township)

Baltimore City

28-04

D. STREET ADDRESS (If rural, give location)

5500 Frederick Ave

c. Length of stay in Baltimore

Life

5. SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan-6-1981

9. AGE (In years last birthday)

69

If Under 1 Year

Months

If Under 24 Hours

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Ellicott City - Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James W. Hilton

14. MOTHER'S MAIDEN NAME

Sarah Mullerius

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

James W. W. W. S. 5500 Fred Ave

ADDRESS

18. 360 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis

DUE TO

1-2 yrs.

(C) Diabetes Mellitus

14 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

No

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April - 20, 1936 to Aug - 15, 1950, that I last saw the deceased alive on Aug - 14, 1950, and that death occurred at 6 A.M., from the causes and on the date stated above.

23A. SIGNATURE

S. Lloyd Johnson

M. D.

23B. ADDRESS

Catonsville, Md

23C. DATE SIGNED

8/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 18/50

24C. NAME OF CEMETERY OR CREMATORY

Western Cemetery Baltimore - Md.

24D. LOCATION (City, town, or county)

Baltimore - Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Wmington Williams, M.D.

25. FUNERAL DIRECTOR

J. B. Hipps, Sr. 1300 Central

ADDRESS

General Thompson

Historical Society
Boston, Mass.

April 20 1891

Dear Sir

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7134

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John William Ruppert JR.

2. DATE
OF
DEATH

Aug. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-03

D. STREET ADDRESS (If rural, give location)

2810 Southern Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Dec. 24-1914

9. AGE (In years
last birthday)

35

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Millwright

10B. KIND OF BUSINESS OR
INDUSTRY

Western Electric

11. BIRTHPLACE (State or foreign country)

BALTO Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Wm. Ruppert

14. MOTHER'S MAIDEN NAME

Helen Schmidt

15. ADDRESS

Southern

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Elizabeth Ruppert-2810

18. E 902.3

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Fracture of ribs and sternum

DUE TO

ANTECEDENT CAUSES

(B) Internal hemorrhage due to laceration of
lung

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C) Multiple contusions, lacerations and abrasions

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Company

Western Electric Company-Point Breeze, Maryland

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 17, 1950 11:15

21E. INJURY OCCURRED
WHILE AT ☒ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

Thrown from scaffold by high pressure
water from broken pipe to wire reels on

22. I certify that I took charge of the remains described above, held an Autopsy ground, thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Durlacher

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Aug. 18, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county) (State)

BALTO

MD

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck 5305 Harford

VS 151

N-861.2

5603M

186a

CERTIFICATE OF DEATH

John W. Miller

Age 72 years

Residence 123 Main St.

City of New York

State of New York

County of New York

Decd. on 12th day of 1900

At New York

Witness my hand and seal

of the City of New York

on the 12th day of 1900

at New York

John W. Miller

John W. Miller

John W. Miller

John W. Miller

John W. Miller

John W. Miller

John W. Miller

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7135

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mr. Ab Mowery

2. DATE
OF
DEATH

8-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

38 Univ. Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Parkville

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3053 ParkTowner Rd 5300

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Apr. 11-1875

9. AGE (In years
last birthday)

75

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nursery Man

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

INDIANA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Mowery

14. MOTHER'S MAIDEN NAME

MARY CARTIFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Marie Mowery 3053 ParkTowner Rd

18.

141X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral Anoxia
Atelectasis & PneumoniaINTERVAL BETWEEN
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Atelectasis & Pneumonia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Post Operative complication

19A. DATE OF OPERATION

8-15-50

19B. MAJOR FINDINGS OF OPERATION

CARCINOMA OF TONGUE

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12-1950, to 8-17-1950, that I last saw the deceased alive on 8-12, 1950, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

William H. Sturge

M. D.

23B. ADDRESS

Univ. Hosp.

23C. DATE SIGNED

8-18-50

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck - 5305 Hartford

UNITED STATES OF AMERICA
DEPARTMENT OF COMMERCE
BUREAU OF MARINE FISHERIES

NO. 1000
FISHING BOAT
NAME
CAPTAIN
LOCALITY
DATE
HOURS
SPECIES
WEIGHT
LENGTH
GIRTH
DETAILS
REMARKS
COLLECTOR
NO. 1000
FISHING BOAT
NAME
CAPTAIN
LOCALITY
DATE
HOURS
SPECIES
WEIGHT
LENGTH
GIRTH
DETAILS
REMARKS
COLLECTOR

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7136

| | | | | | |
|--|---------------------------|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Charles Jorss</i> | | 2. DATE OF DEATH <i>17 Aug 50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>4345 Reisterstown Rd.</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore City</i> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>60 Charles Reisterstown</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-13</i> | | | |
| c. Length of stay in Baltimore <i>72 yrs</i> | | D. STREET ADDRESS (If rural, give location) <i>4345 Reisterstown Rd.</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i> | 8. DATE OF BIRTH <i>25 July 1878</i> | 9. AGE (In years last birthday) <i>72 yrs</i> | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>asst. treasurer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>shipping</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ind.</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>John A. William Jorss</i> | | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Romer</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>yes</i> | | 16. SOCIAL SECURITY NO. <i>213-03-7863</i> | | 17. INFORMANT ADDRESS <i>C. Rodgers Jorss 609 Midland Mill Rd. Pikesville 8 Md.</i> | |
| 18. <i>1/63X</i> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Carcinoma of lung, at</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> | |
| ANTECEDENT CAUSES | | (B) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>18 June 50</i> | | 19B. MAJOR FINDINGS OF OPERATION <i>Probable carcinoma of lung</i> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>2 May, 1950</i> to <i>17 Aug, 1950</i> , that I last saw the deceased alive on <i>16 Aug, 1950</i> , and that death occurred at <i>12:30 Pm.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Paul H. Royce</i> | | 23B. ADDRESS <i>Pikesville 8 Rd.</i> | | 23C. DATE SIGNED <i>17 Aug 50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Aug 21-50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Summit Ridge</i> | |
| 24D. LOCATION (City, town or county) (State) <i>Pikesville Md.</i> | | 24E. FUNERAL DIRECTOR <i>Everett Dumas</i> | | 24F. ADDRESS <i>471</i> | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 18 1950</i> | | REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i> | | 25. FUNERAL DIRECTOR <i>Everett Dumas</i> | |

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1911

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

Very truly yours,

W. L. RORER, Secretary.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7137

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edward Gibson

2. DATE
OF
DEATH

August 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1817 Ashland Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

7-05

D. STREET ADDRESS (If rural, give location)

1817 Ashland Ave.

c. Length of stay in Baltimore

32 yrs.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

April 8, 1911

9. AGE (in years last birthday)

59

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Winnsboro SC.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edward Gibson

14. MOTHER'S MAIDEN NAME

Georgianna?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Georgia Gibson

ADDRESS

1817 Ashland Ave.

18. 163 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral Degenerability

3 mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Carcinoma of Lung

6 mo

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 29, 1950 to Aug 18, 1950, that I last saw the deceased alive on Aug 12, 1950, and that death occurred at 7 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. J. Thifone

M. D.

23B. ADDRESS

1422 E. Ross St

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

A. A. County Md.

(State)

REGISTRAR'S SIGNATURE

R. W. Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. C. G. Elliott & Daughters

ADDRESS

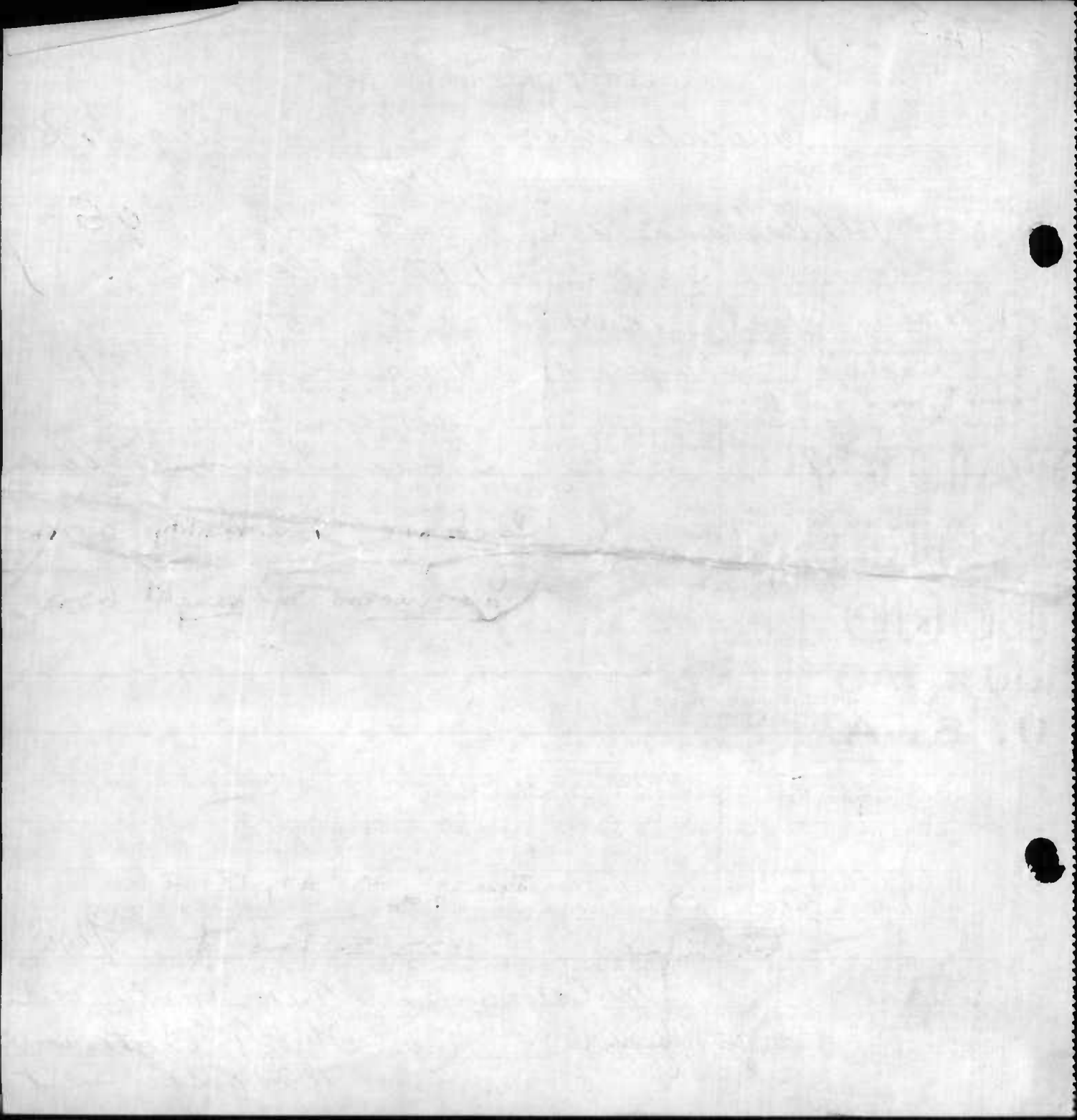
1129 N. Caroline St

AUG 18 1950

VS 150

7408F

47D



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7138
Registered No.

| | | | | | |
|--|----------------------------------|---|--------------------------------------|---|-------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Edwin Seitz</i> | | 2. DATE OF DEATH <i>8/18/50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i> | | C. CITY OR TOWN (If outside corporate limits write B.U.M.D. and give township) <i>Baltimore</i> | | | |
| C. Length of stay in Baltimore <i>Life</i> | | D. STREET ADDRESS (If rural, give location) <i>2330 Tilden St.</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i> | 8. DATE OF BIRTH <i>4-17-1896</i> | 9. AGE (In years last birthday) <i>54</i> | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cressman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Printing Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 13. FATHER'S NAME <i>Albert Seitz</i> | | 14. MOTHER'S MAIDEN NAME <i>Kornie Horney</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i> | | 16. SOCIAL SECURITY NO. <i>215-01-7527</i> | | 17. INFORMANT <i>Wife - Mrs. Grace Seitz</i> | |
| 18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Sub-archival hemorrhage</i> | | CAUSE OF DEATH (A) <i>Sub-archival hemorrhage</i> DUE TO (B) <i>Hypertensive Poles - vascular disease</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>none</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>8/17/50</i> , 19 <i>50</i> , to <i>8/18/50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>8/18/50</i> , 19 <i>50</i> , and that death occurred at <i>2:30</i> m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Thomas S. Stouffer</i> | | 23B. ADDRESS <i>Mercy Hospital</i> | | 23C. DATE SIGNED <i>8/18/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/21/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | 25. FUNERAL DIRECTOR <i>Wm. Cook, Inc.</i> | | ADDRESS <i>1217 St Paul St.</i> | |

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E.V.

Registered No.

50 7139

BIRTH NO. 48-28290

1. NAME OF DECEASED
(Type or Print)

Naomi

STUKES

2. DATE
OF
DEATH

August 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1738 Llewellyn St.

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Dec. 23,

9. AGE (In years
last birthday)

1

10. Under 1 Year
Months Days

8

—

—

11. Under 24 Hours
Hours Min.

—

—

—

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Samuel S. Stukes.

14. MOTHER'S MAIDEN NAME

Dorothy Logan.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Alice Stukes

ADDRESS
419 Colfax Way,
Green Station.

18. E883.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Ingestion of unknown caustic agent

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☒ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1738 Llewellyn St.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 16, 1950 abt. 4 A.M.

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

WORK ☐AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingestion of unknown caustic agent not
recovered at hospital or in the toxicologic22. I certify that I took charge of the remains described above, held an Autopsy logical thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

23A. SIGNATURE

William V. Gold

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D.

23C. DATE SIGNED

August 17, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-19-1950.

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

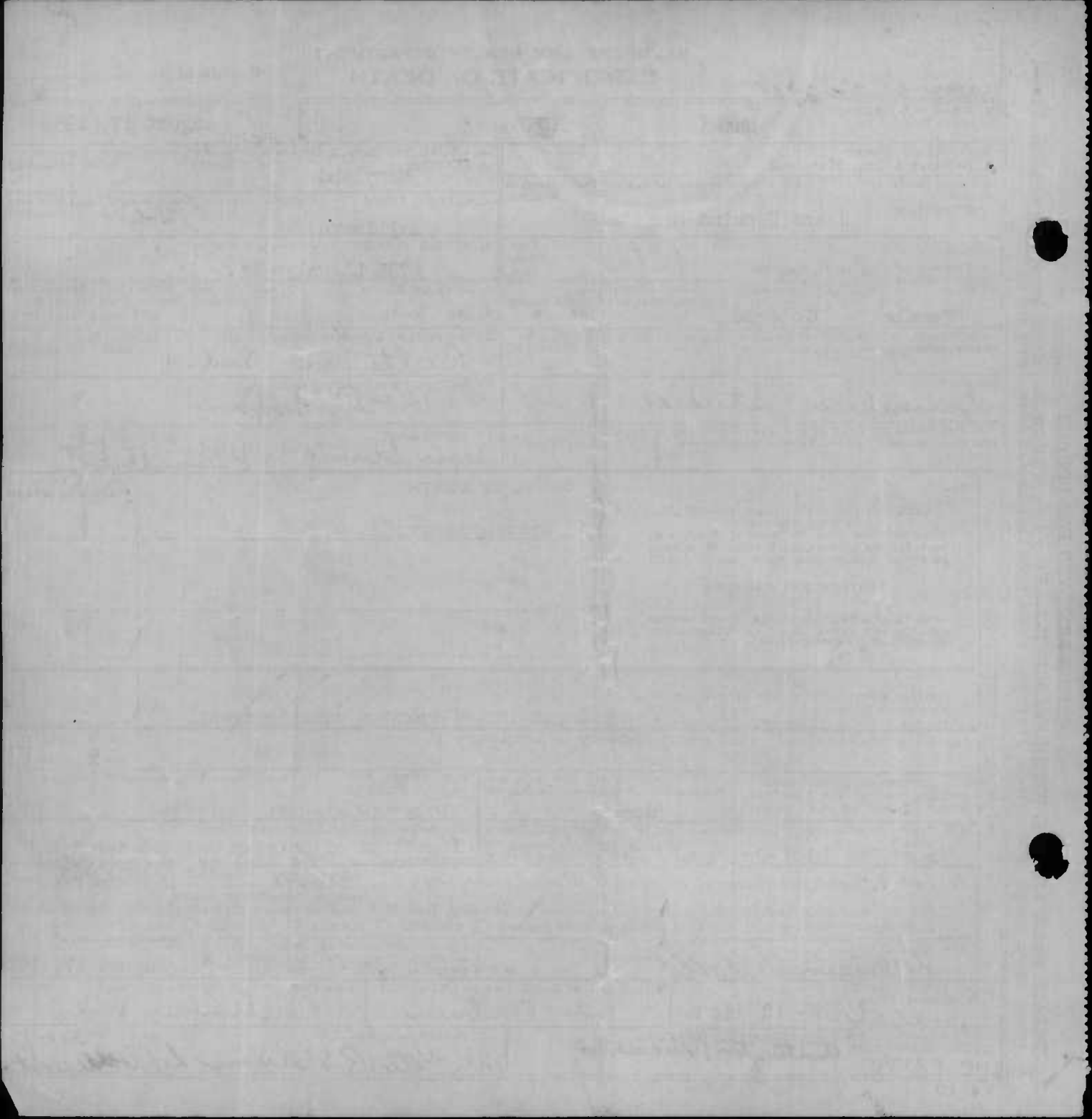
Mrs. Katie R. Williams Schroeder St.

AUG 18 1950

VS 151

N-964.0

179x



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 7140

BIRTH NO.

 1. NAME OF DECEASED
(Type or Print)

Fannie Henderson,

 2. DATE
OF
DEATH

Aug. 17, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

1610 W. Lexington St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore. 19-02

C. Length of stay in Baltimore

 Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1610 W. Lexington St.

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

September 15, 1881

9. AGE (In years, last birthday)

68

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lancaster Co., Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Rachel Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

William Henderson. 1610 W. Lexington

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

Endocarditis 2 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

 YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

 WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 18, 1948 to Aug 17, 1950, that I last saw the deceased alive on Aug 17, 1950, and that death occurred at 1 A.M., from the causes and on the date stated above.

23A. SIGNATURE

W. H. Watt

23B. ADDRESS

5154 Lexington

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-21-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

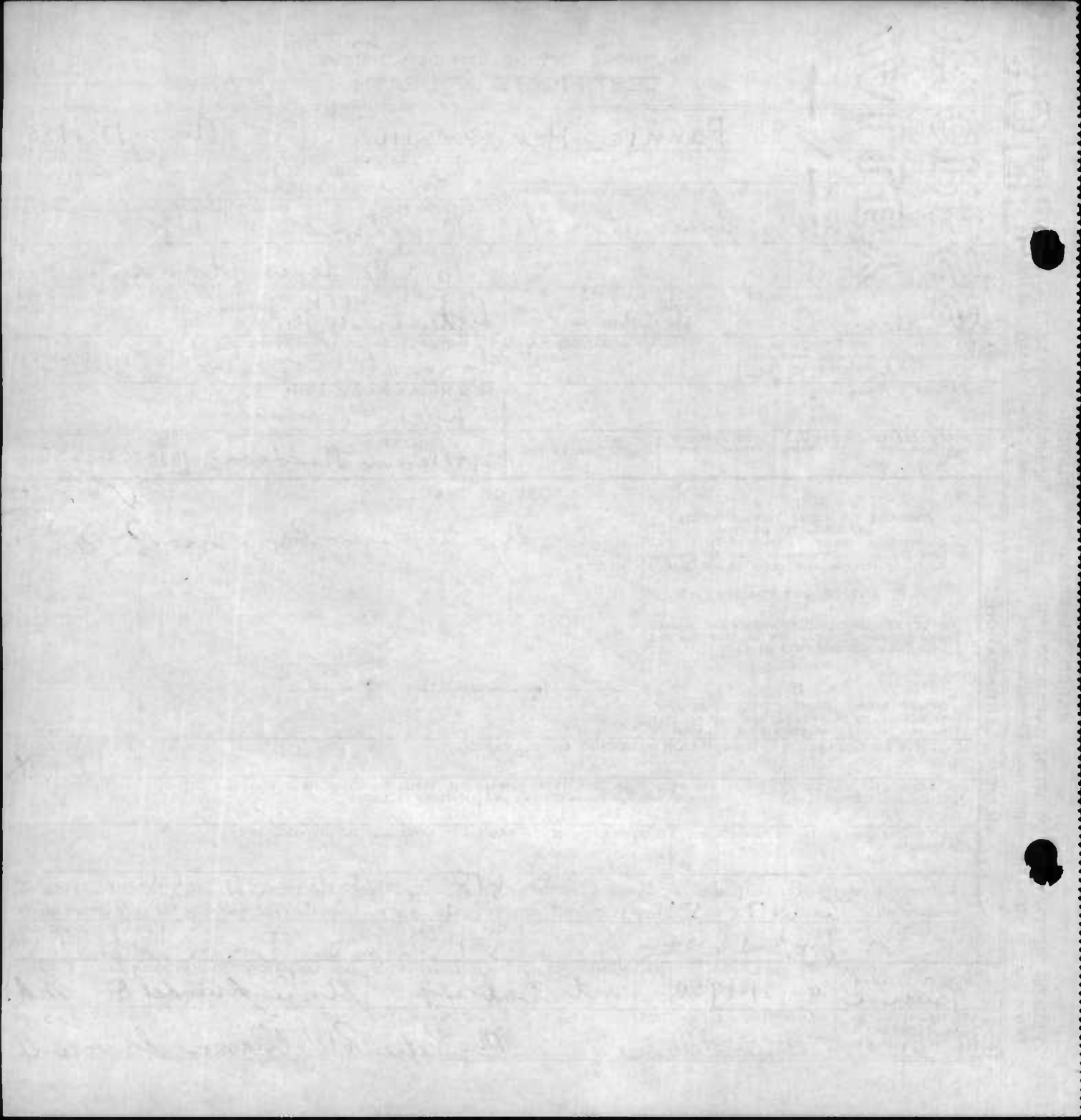
Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Mrs. Kate R. Williams

ADDRESS

322 N. Schroeder St.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7141
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John

FISHER

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

618 W. Fairmount St. Ave

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

April 16, 1890

9. AGE (In years last birthday)

60

10. Under 1 Year Months Days

4

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Eastern Shore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Fisher

14. MOTHER'S MAIDEN NAME

Sarah Wieg.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mabel Matthews, 729 W. Fairmount

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED
Aug. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-21-1950

24C. NAME OF CEMETERY OR CREMATORY

mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams Schroeder St.

ADDRESS

V S 151

97024

1313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

STATE OF NEW YORK
IN SENATE
JANUARY 19, 1909.

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1908.

ALBANY:

JOHN W. BAKER, PRINTING OFFICE.

1909.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Every item of information should be carefully supplied. The correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7142

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Harriet M. Knight

2. DATE
OF
DEATH

8/17/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2305 Maryland Ave. St. Paul St.

C. CITY OR TOWN (If outside corporate limits, write R.U.R. (1. and give township)
Baltimore 12-05

C. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)
102 W North Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. 332X I

CAUSE OF DEATH

Hemiplegia, left.
cerebral thrombosis

INTERVAL BETWEEN ONSET AND DEATH
1 week
1 week

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Aug 17, 1950 that I last saw the deceased alive on Aug 16, 1950, and that death occurred at 12:20 pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7143

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)NELLIE VIRGINIA BROWN.2. DATE
OF
DEATH8/17/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT WORK

NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from 8/14, 1950, to 8/17, 1950, that I last saw the deceased alive on 8/17, 1950, and that death occurred at 7:05 P m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------------------|--|------------------------------------|--|------------------------------------|--|------------------------------------|--|--|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | | 4. Date of Birth | | 5. Date of Death | |
| 6. Place of Birth | | 7. Occupation | | 8. Cause of Death | | 9. Manner of Death | | 10. Signature of Registrar | |
| 11. Signature of Physician | | 12. Signature of Coroner | | 13. Signature of Medical Examiner | | 14. Signature of Health Officer | | 15. Signature of County Clerk | |
| 16. Signature of Town Clerk | | 17. Signature of Village Clerk | | 18. Signature of Ward Clerk | | 19. Signature of Precinct Clerk | | 20. Signature of School District Clerk | |
| 21. Signature of Religious Society | | 22. Signature of Burial Society | | 23. Signature of Undertaker | | 24. Signature of Funeral Home | | 25. Signature of Cemetery | |
| 26. Signature of Mortuary | | 27. Signature of Embalmer | | 28. Signature of Transporter | | 29. Signature of Interment | | 30. Signature of Burial | |
| 31. Signature of Cremation | | 32. Signature of Disposition | | 33. Signature of Final Disposition | | 34. Signature of Final Disposition | | 35. Signature of Final Disposition | |
| 36. Signature of Final Disposition | | 37. Signature of Final Disposition | | 38. Signature of Final Disposition | | 39. Signature of Final Disposition | | 40. Signature of Final Disposition | |
| 41. Signature of Final Disposition | | 42. Signature of Final Disposition | | 43. Signature of Final Disposition | | 44. Signature of Final Disposition | | 45. Signature of Final Disposition | |
| 46. Signature of Final Disposition | | 47. Signature of Final Disposition | | 48. Signature of Final Disposition | | 49. Signature of Final Disposition | | 50. Signature of Final Disposition | |
| 51. Signature of Final Disposition | | 52. Signature of Final Disposition | | 53. Signature of Final Disposition | | 54. Signature of Final Disposition | | 55. Signature of Final Disposition | |
| 56. Signature of Final Disposition | | 57. Signature of Final Disposition | | 58. Signature of Final Disposition | | 59. Signature of Final Disposition | | 60. Signature of Final Disposition | |
| 61. Signature of Final Disposition | | 62. Signature of Final Disposition | | 63. Signature of Final Disposition | | 64. Signature of Final Disposition | | 65. Signature of Final Disposition | |
| 66. Signature of Final Disposition | | 67. Signature of Final Disposition | | 68. Signature of Final Disposition | | 69. Signature of Final Disposition | | 70. Signature of Final Disposition | |
| 71. Signature of Final Disposition | | 72. Signature of Final Disposition | | 73. Signature of Final Disposition | | 74. Signature of Final Disposition | | 75. Signature of Final Disposition | |
| 76. Signature of Final Disposition | | 77. Signature of Final Disposition | | 78. Signature of Final Disposition | | 79. Signature of Final Disposition | | 80. Signature of Final Disposition | |
| 81. Signature of Final Disposition | | 82. Signature of Final Disposition | | 83. Signature of Final Disposition | | 84. Signature of Final Disposition | | 85. Signature of Final Disposition | |
| 86. Signature of Final Disposition | | 87. Signature of Final Disposition | | 88. Signature of Final Disposition | | 89. Signature of Final Disposition | | 90. Signature of Final Disposition | |
| 91. Signature of Final Disposition | | 92. Signature of Final Disposition | | 93. Signature of Final Disposition | | 94. Signature of Final Disposition | | 95. Signature of Final Disposition | |
| 96. Signature of Final Disposition | | 97. Signature of Final Disposition | | 98. Signature of Final Disposition | | 99. Signature of Final Disposition | | 100. Signature of Final Disposition | |

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7144
Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|-------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Nellie C. De Paola</i> | | | 2. DATE OF DEATH <i>August 17, 1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>4661 Park Heights Ave</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>27-16</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION _____ | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore Maryland</i> | | |
| c. Length of stay in Baltimore <i>Life</i> Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) <i>4661 Park Heights Ave</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>Oct. 12, 1912</i> | 9. AGE (in years last birthday) <i>37</i> | 10. Under 1 Year Months: _____ Days: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Daniel A. McKenna</i> | | | 14. MOTHER'S MAIDEN NAME <i>Ellen C. Ryan</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT ADDRESS <i>Mr. Vincent A. De Paola 4661 Park Heights Ave</i> | |

| | | |
|--|---|--|
| 1B. <i>002X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH (A) <i>Pulmonary tuberculosis</i> DUE TO (B) _____ DUE TO (C) _____ | INTERVAL BETWEEN ONSET AND DEATH <i>8 years</i> |
|--|---|--|

| | | | | | |
|---|--|--|---|--|--|
| 19A. DATE OF OPERATION <i>none</i> | | 19B. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from <i>Oct.</i> , 19 <i>45</i> , to <i>Aug. 16</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Aug. 16</i> , 19 <i>50</i> , and that death occurred at <i>6 A.</i> m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Bayan D. Seigel</i> M. D. | | 23B. ADDRESS <i>15 Tremont Rd</i> | | 23C. DATE SIGNED <i>Aug. 17, 1950</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>Aug. 19, 1950</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>New Catholic Cemetery</i> | 24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | (State) _____ | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>Aug 18 1950</i> | REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>Loring Byers</i> | | ADDRESS <i>5005 Park Heights Ave</i> | |

VS 150

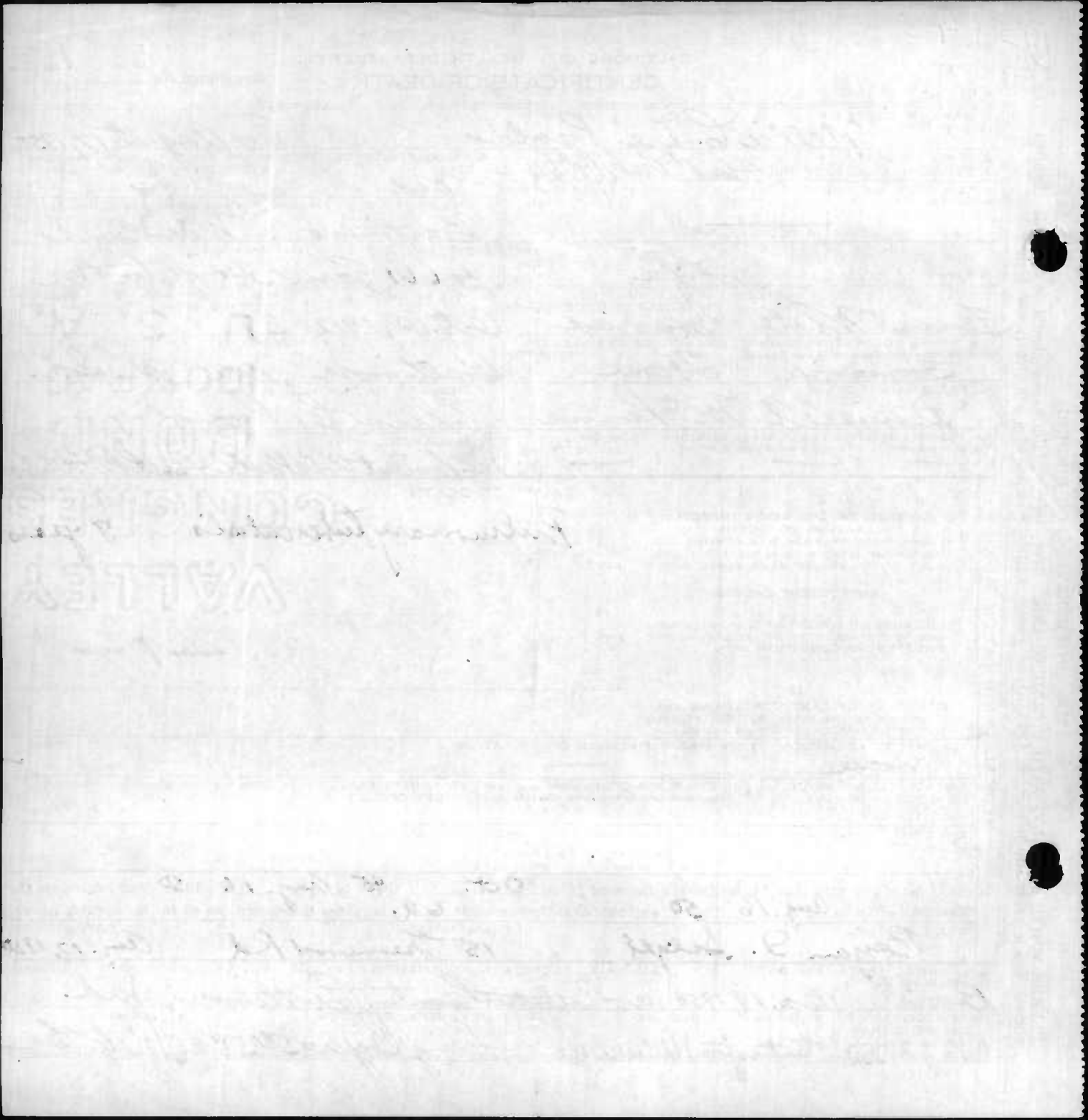
1313

PLEASE WRITE IN FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING

D-140



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7145

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. BROCKMAN

2. DATE
OF
DEATH

AUGUST 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

UNION MEMORIAL HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3800 EDNOR ROAD

c. Length of stay in Baltimore

63

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

MAY 27, 1887

9. AGE (In years
last birthday)

63

H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Partner

10B. KIND OF BUSINESS OR
INDUSTRY

Cigar Mfg. Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM H. BROCKMAN

14. MOTHER'S MAIDEN NAME

MARY SCHEAFFER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL
SECURITY NO.

215-09-4507

17. INFORMANT

ELSIE F. BROCKMAN

ADDRESS

3800 EDNOR ROAD, BALTIMORE

18.

541.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Gastrointestinal Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

7 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Duodenal Ulcer.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

AUGUST 13, 1950

19B. MAJOR FINDINGS OF OPERATION

BLEEDING DUODENAL ULCER

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 11, 1950, to August 17, 1950, that I last saw the
deceased alive on August 17, 1950, and that death occurred at 1:35 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Alvin Bongelaar

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

Aug 17, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8/19/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.

ADDRESS

BALTO., 13, MD.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

VS 150

290 4A

117B

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

RECEIVED MAY 10 1900

Handwritten text, likely a signature or name, possibly "J. H. ..."

Handwritten text at the bottom of the page, possibly a date or address, including "May 10 1900"

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 7146**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HELEN FRANCES PFAFF

2. DATE
OF
DEATH

Aug. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3339 Moravia Blvd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3339 Moravia Blvd.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

April 5, 1910

9. AGE (In years
last birthday)

40

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Frank Sluka

14. MOTHER'S MAIDEN NAME

Sophia Jindra

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Wm. G. Pfaff, husband, 3339 Moravia Blvd.

18.

174X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma, uterus

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

3 months

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from July 19, 1950, to Aug 16, 1950, that I last saw the
deceased alive on Aug 16, 1950, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles N. Seacil

M. D.

23B. ADDRESS

3601 Ailesa Ave

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

4430 Belair Rd. Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.

2601-3-5 E. Madison St.

AUG 18 1950

48 B

STATE OF NEW YORK
CERTIFICATE OF DEATH

| | | | | | | | |
|-------------------------------|--|---------------------------------|--|--------------------------------|--|-------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of death | |
| 5. Place of death | | 6. Cause of death | | 7. Manner of death | | 8. Signature of physician | |
| 9. Signature of registrar | | 10. Signature of informant | | 11. Signature of witness | | 12. Signature of coroner | |
| 13. Signature of undertaker | | 14. Signature of funeral home | | 15. Signature of cemetery | | 16. Signature of church | |
| 17. Signature of family | | 18. Signature of friends | | 19. Signature of neighbors | | 20. Signature of community | |
| 21. Signature of state | | 22. Signature of federal | | 23. Signature of international | | 24. Signature of world | |
| 25. Signature of universe | | 26. Signature of nature | | 27. Signature of science | | 28. Signature of art | |
| 29. Signature of music | | 30. Signature of literature | | 31. Signature of philosophy | | 32. Signature of religion | |
| 33. Signature of politics | | 34. Signature of economics | | 35. Signature of sociology | | 36. Signature of psychology | |
| 37. Signature of anthropology | | 38. Signature of history | | 39. Signature of geography | | 40. Signature of astronomy | |
| 41. Signature of meteorology | | 42. Signature of biology | | 43. Signature of chemistry | | 44. Signature of physics | |
| 45. Signature of mathematics | | 46. Signature of logic | | 47. Signature of ethics | | 48. Signature of aesthetics | |
| 49. Signature of law | | 50. Signature of medicine | | 51. Signature of dentistry | | 52. Signature of nursing | |
| 53. Signature of pharmacy | | 54. Signature of veterinary | | 55. Signature of agriculture | | 56. Signature of industry | |
| 57. Signature of commerce | | 58. Signature of transportation | | 59. Signature of communication | | 60. Signature of energy | |
| 61. Signature of environment | | 62. Signature of education | | 63. Signature of culture | | 64. Signature of society | |
| 65. Signature of government | | 66. Signature of justice | | 67. Signature of peace | | 68. Signature of love | |
| 69. Signature of hope | | 70. Signature of faith | | 71. Signature of charity | | 72. Signature of kindness | |
| 73. Signature of compassion | | 74. Signature of forgiveness | | 75. Signature of patience | | 76. Signature of humility | |
| 77. Signature of gentleness | | 78. Signature of self-control | | 79. Signature of perseverance | | 80. Signature of courage | |
| 81. Signature of strength | | 82. Signature of wisdom | | 83. Signature of understanding | | 84. Signature of knowledge | |
| 85. Signature of truth | | 86. Signature of beauty | | 87. Signature of goodness | | 88. Signature of happiness | |
| 89. Signature of joy | | 90. Signature of peace | | 91. Signature of love | | 92. Signature of life | |
| 93. Signature of death | | 94. Signature of resurrection | | 95. Signature of eternal life | | 96. Signature of heaven | |
| 97. Signature of hell | | 98. Signature of purgatory | | 99. Signature of limbo | | 100. Signature of nothingness | |

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

Registered No.

50 7147

BIRTH NO.

| | | | | | |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) George Kaufman JOHN / (KAUFMAN), Jr. | | | 2. DATE OF DEATH August 15, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore life | | | D. STREET ADDRESS (If rural, give location) 2006 E. Lanvale Street | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Jan. 17, 1890 | | 9. AGE (In years last birthday) 60 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner | | 10B. KIND OF BUSINESS OR INDUSTRY Park Board | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME John G. Kaufman, Sr. | | | 14. MOTHER'S MAIDEN NAME Catherine McMinnick | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Margaret Boeh Kaufman, wife, above | | |

| | | |
|--|--|----------------------------------|
| 18. E903.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Skull fracture with subdural hemorrhage DUE TO (A) Laceration of brain DUE TO (B) Rheumatic heart disease DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) public place | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Lovell's West Shore Grove, Greenhaven, Md. | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 13, 1950 midnight | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? walk Fell on cement/while intoxicated | |
| 22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | | |
| 23A. SIGNATURE William V. Smith | | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/> | | 23C. DATE SIGNED August 16, 1950 | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 19, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State) 4430 Belair Rd., Baltimore, Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR 8-17-50 | | REGISTRAR'S SIGNATURE Thurston Williams, M.D. | | 25. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 2601-3-5 E. Madison St. | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 7148

BIRTH NO.

I. NAME OF DECEASED
(Type or Print)

William Weise

2. DATE
OF
DEATH

Aug. 16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

2724 Edmondson Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2724 Edmondson Ave.

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE. MARRIED.

Widower

8. DATE OF BIRTH

April 15, 1876

9. AGE (In years last birthday)

74

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman, Cigars, Middleman & Weise

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry Weise

14. MOTHER'S MAIDEN NAME

Louisa-----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. May Mercer, 2724 Edmondson Ave.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

CAUSE OF DEATH

Metastasis from bladder.

INTERVAL BETWEEN ONSET AND DEATH

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

malignancy of bladder

2-3 yrs.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30-41, 1941, to 8-16-50, 1950, that I last saw the deceased alive on 8-12-50, 1950, and that death occurred at 10-30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Harry S. Shindel

M. D.

23B. ADDRESS

2203 Edmondson

23C. DATE SIGNED

8-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 21/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park, 3801 Frederick Rd. Baltimore 29, Md

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Harry S. Shindel

ADDRESS

4101 Edmondson Ave.

VS 150

490 68

52 B

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

Washington, D.C.

1900

June 10, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 6th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

Wm. H. Hays

Director

Bureau of Plant Industry

Washington, D.C.

Enclosed for you are

two copies of the

report of the

Commissioner of

Patents and

Trademark Office

relative to the

application of

the United States

Patent Office

for the registration

of the trademark

of the United States

Patent Office

for the registration

of the trademark

of the United States

Patent Office

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 7149

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Meta Boldt

2. DATE
OF
DEATH

Aug. 18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTION) **General German Aged Peoples Home, 22 S. Athol Ave.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

22 S. Athol Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX
Female

6. COLOR OR RACE
W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Nov. 1863

9. AGE (In years
last birthday)

10 Under 1 Year 11 Under 24 Hours
Months: Days Hours: Min.

86

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Martin Boldt

14. MOTHER'S MAIDEN NAME

Dorothea Oemken

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mr. J. George Walz, 22 S. Athol Ave

18. **493X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cardio-Respiratory failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Pneumonia

II

(C) DUE TO

Senility

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 10, 1950** to **Aug 18, 1950** that I last saw the deceased alive on **Aug 18, 1950**, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

Aug. 21/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county) (State)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

Harriet A. White

ADDRESS

4101 Edmondson Ave.

VS 150

10912

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

DATE: 10/10/60

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/60

TO: SAC, NEW YORK

RE: [Illegible]

DATE: 10/10/60

1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]
6. [Illegible]
7. [Illegible]
8. [Illegible]
9. [Illegible]
10. [Illegible]

DATE: 10/10/60

TO: SAC, NEW YORK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELIZA JANE (JANYE) HESS

Janyee Hess

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

3117 Kenyon Ave.,

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 30, 1871

9. AGE (In years
last birthday)

79

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Albert

14. MOTHER'S MAIDEN NAME

Sarah Ann McPhail

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Wm. C. Albert
3624 Yofando Rd

ADDRESS

18.

E900.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Fracture Skull with Cerebral

DUE TO

Concussion

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CERTIFICATION APPROVED BY

DR. John R. DAVIS

per: Stanley A. Dunsen
M. D.

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)
Accident21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)
Home21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)
Home21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 16, 1950 m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR? (Slipped)

Fell down steps

22. I hereby certify that I attended the deceased from August 16, 1950, to August 16, 1950, that I last saw the
deceased alive on August 16, 1950, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

William M. Paul

M. D.

23B. ADDRESS

1100 N. Caroline St.

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8/19/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

HENRY SANDERSON & SONS, INC.

BALTIMORE - 18, Md.

ADDRESS

Seng T. Paul

AUG 18 1950

VS 150

N-803.2

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

RECEIVED AT THE LIBRARY, HERE

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7151

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sadie Anello

2. DATE
OF
DEATH

August 16th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

City

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

2002 E. Fayette Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2002 E. Fayette Street

c. Length of stay in Baltimore

52 Yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 6th., 1889

9. AGE (In years
last birthday)

60

H Under 1 Year
Months: Days

9 10

H Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR
INDUSTRY

Clothing (Mens)

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Dominic Buttone

14. MOTHER'S MAIDEN NAME

Lena Buckerrri

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

215-07-4775

17. INFORMANT

ADDRESS

Salvatore Anello, 2002 E. Fayette St.

18.

154X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of Rectum

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

14 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) metastasis in liver

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 9th, 1949, to Aug 16th, 1950, that I last saw the
deceased alive on 8/16th, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Harry J. Janke

M. D.

23B. ADDRESS

100 W. Miller St

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-19-50

24C. NAME OF CEMETERY OR CREMATORY

Most Holy Redeemer

24D. LOCATION (City, town, or county) (State)

Belair Road, Balto: Md.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 18 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc. - I735 Harford Avenue

DECLARATION OF DEATH

| | | | |
|-----------------------|--|------------------------------|--|
| Name of Deceased | | Date of Death | |
| Sex | | Age | |
| Place of Birth | | Usual Residence | |
| Cause of Death | | Manner of Death | |
| Physician's Signature | | Medical Examiner's Signature | |
| Date | | Time | |
| Place | | City | |
| County | | State | |
| Registrar's Signature | | Registrar's Office | |
| Date | | Time | |
| Place | | City | |
| County | | State | |

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 7152

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

IVANCY W. WISE.

2. DATE
OF
DEATH

8/18/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md. 20-02

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

Charmel House & Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 23.

C. Length of stay in Baltimore

10 yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3138 Pennrose Ave.

5. SEX

F.

6. COLOR OR RACE

White.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married.

8. DATE OF BIRTH

3/29/1919.

9. AGE (In years
last Birthday)

31 yrs.

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife.

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Pennsylvania.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harvey Baker.

14. MOTHER'S MAIDEN NAME

Helen Bowers.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS Home
City Hospital,

18. 170X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Diphtheria Carcinoma tons. 7 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Carcinoma of throat

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/13/1950 to 8/18/1950, that I last saw the
deceased alive on 8/18/1950, and that death occurred at 6:05 pm., from the causes and on the date stated above.

23A. SIGNATURE

Ruth Moore MD

M. D.

23B. ADDRESS

Charmel House & Hospital

23C. DATE SIGNED

8/18/50

24. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 22-50

24C. NAME OF CEMETERY OR CREMATORY

Valley Forge Garden Spring of Pennsylvania Pa

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 19 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Geo. X. Beyer Jr 1512 Hollands St

ADDRESS

If possible, state a
more definite
anatomical location
of malignancy

See Document File 50-7152

9.5.50

ES

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 7153**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Annie Elizabeth Green.

2. DATE
OF
DEATH

August 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION Baltimore City Hospitals
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4940 Eastern Ave

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 8-1870

9. AGE (in years last birthday)

80

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Benjamin C. Gaman

14. MOTHER'S MAIDEN NAME

Mary Welch.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH more than 1 yr.

3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ No ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July 8, 1947 to July 17, 1950 that I last saw the deceased alive on July 17, 1950 and that death occurred at 11:35 AM from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

8-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FEDERAL DIRECTOR

ADDRESS

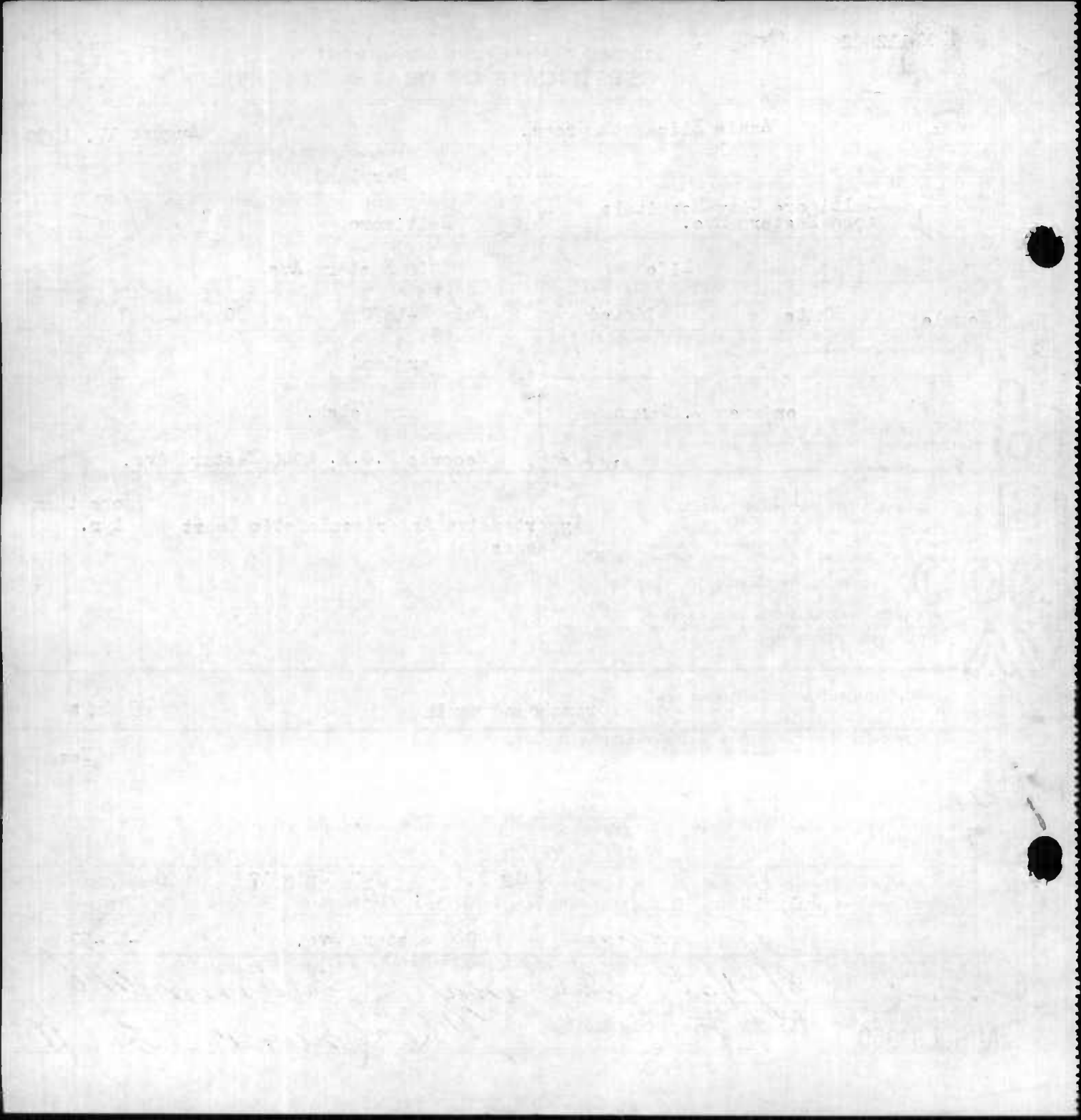
1219 St Paul

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7154

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Thomas

Murphy

2. DATE
OF
DEATH

August 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, with RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

418 W. 23rd St.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

July 16, 1896

9. AGE (In years
last birthday)

34

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Machine operator

10B. KIND OF BUSINESS OR
INDUSTRY

Crown Cork & Seal Co.

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

Md

13. FATHER'S NAME

Thomas O Murphy

14. MOTHER'S MAIDEN NAME

Mary White

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Coronary artery sclerosis

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
m. WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Stanley H. Dunleavy M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Aug. 18, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

St. Catharine

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, Md

25. FUNERAL DIRECTOR

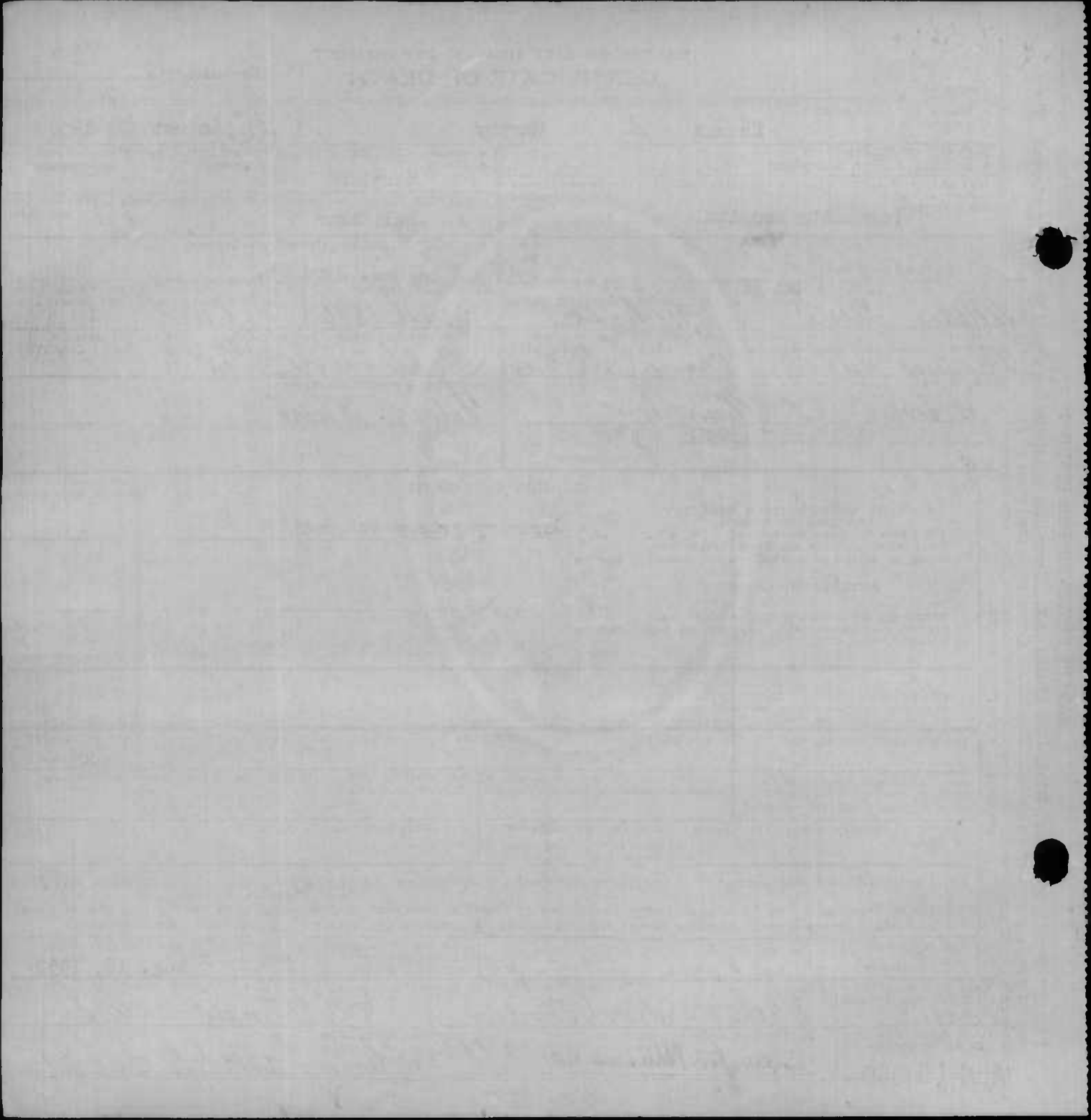
1214 St Paul St

ADDRESS

AUG 19 1950

690 32

94a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7155
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Hubert Hamilton Hart

2. DATE
OF
DEATH

Aug 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Maryland**

B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION
**Crawford Retreat
2117 Denison St.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
1162 Carroll St.

c. Length of stay in Baltimore

57 years

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

Feb. 8, 1873

9. AGE (In years last birthday)

77

If Under 1 Year
Months: Days

6 8

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Elevator Operator

10B. KIND OF BUSINESS OR INDUSTRY

Md. Coloer Printing Co.

11. BIRTHPLACE (State or foreign country)

Augusta Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Job Hart

14. MOTHER'S MAIDEN NAME

Louisa Earhart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-09-6385

17. INFORMANT

ADDRESS

Miss Alta Hart 1162 Carroll St

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Hypostatic Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Carcinoma of Prostate

(C) DUE TO

Metastases to heart & lung

3 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **8/15/50**, to **8/16/50**, that I last saw the deceased alive on **8/16/50**, and that death occurred at **7:30 PM**, from the causes and on the date stated above.

23A. SIGNATURE

Joseph L. Lawrence

M. D.

23B. ADDRESS

679 W. North Ave. Baltimore, Md.

23C. DATE SIGNED

8/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 19, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave

AUG 19 1950

51B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Aug 10, 1950

Walter

My dear Walter
I have just
received your
letter of the
10th and am
glad to hear
from you.

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7156

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SHAW, HARRY

2. DATE
OF
DEATH

8-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balt - Md

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hosp

C. CITY OR TOWN

Pocomoke City Pocomoke

c. Length of stay in Baltimore

4 day

D. STREET ADDRESS (If rural, give location)

Poco. Road 7339

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1-8-96

9. AGE (In years,
last birthday)

54

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Self employed

10B. KIND OF BUSINESS OR
INDUSTRY

Electric supplies

11. BIRTHPLACE (State, or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm. S. Shaw

14. MOTHER'S MAIDEN NAME

Rhea Stearns

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Emma P Shaw Pocomoke City

18. 298.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pulmonary embolism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Atherosclerosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Bartter's Syndrome

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 8-14, 1950, to 8-18, 1950, that I last saw the
deceased alive on 8-18, 1950, and that death occurred at 2:45 Pm., from the causes and on the date stated above.

23A. SIGNATURE

James Blaser

M. D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-20-50

24C. NAME OF CEMETERY OR CREMATORY

Presbyterian

24D. LOCATION (City, town, or county)

Pocomoke City, Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

2502

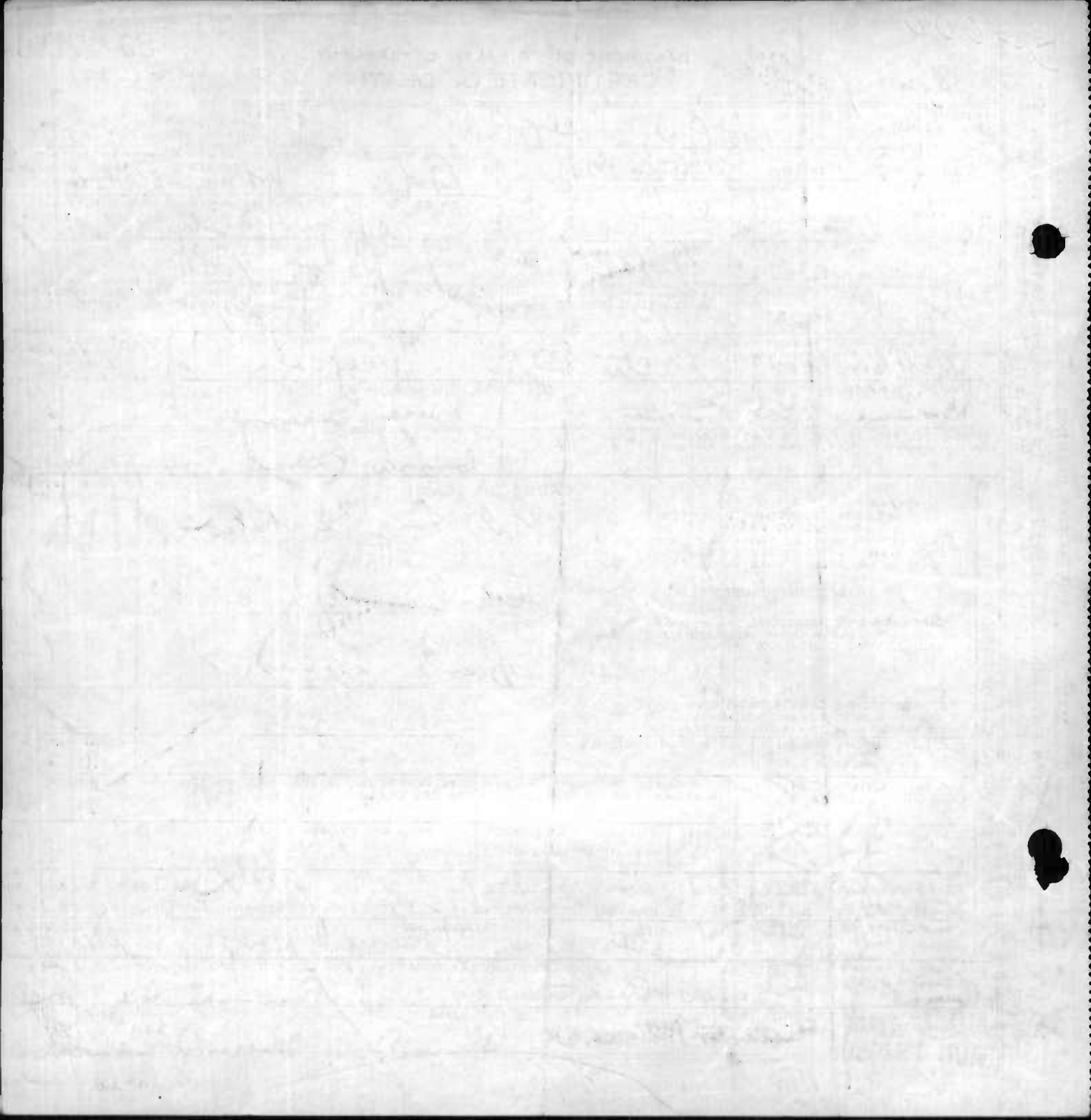
AUG 19 1950

VS 150

2906P

124a

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7157

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Reva M. Short

2. DATE
OF
DEATH

8/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Maryland Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

Balt

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

21-01

D. STREET ADDRESS (If rural, give location)

719 McHenry St. #30

c. Length of stay in Baltimore

7

78 Yrs.
36 Mos.
Days

5. SEX

F

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

May 2, 1876

9. AGE (In years
last birthday)

74

If Under 1 Year
Months: Days

3 16

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

house work

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Lides L. Short

14. MOTHER'S MAIDEN NAME

Anne Horde

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Wing Short (Brother)

ADDRESS

719 McHenry St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

Carcinoma of Stomach

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

6-12 mo.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8/17/50

19B. MAJOR FINDINGS OF OPERATION

Massive Carcinoma of stomach with metastases

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/31, 1950, to 8/18, 1950, that I last saw the
deceased alive on 8/18, 1950, and that death occurred at 3:05 Am., from the causes and on the date stated above.

23A. SIGNATURE

D. E. Bryant

M. D.

23B. ADDRESS

Maryland Gen. Hosp.

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-19-50

24C. NAME OF CEMETERY OR CREMATORY

Landon Park

24D. LOCATION (City, town, or county)

Frederick Rd

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 19 1950

REGISTRAR'S SIGNATURE

Wilmington Williams

25. FUNERAL DIRECTOR

C. J. Schuchman 703 McHenry St.

ADDRESS

VS 150

720 8A

46 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint handwritten notes at the bottom of the page]

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7158
Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <p align="center">Edward O. Dexter</p> | | | 2. DATE OF DEATH <p align="center">Aug 19 1950</p> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 4108 Penhurst Ave B. FULL NAME OF HOSPITAL OR INSTITUTION 00 | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 15-10 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4108 Penhurst Ave | | |
| c. Length of stay in Baltimore <p align="center">25 Yrs. Mos. Days</p> | | | 8. DATE OF BIRTH June 17 1877 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 9. AGE (In years, last birthday) 73 | | 11. BIRTHPLACE (State or foreign country) Wales |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman | | | 10B. KIND OF BUSINESS OR INDUSTRY DRUGS (M) | | |
| 13. FATHER'S NAME Benjamin Dexter | | | 14. MOTHER'S MAIDEN NAME Mary J. Hill | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mary E. Dexter 4108 Penhurst Ave | | | ADDRESS | | |

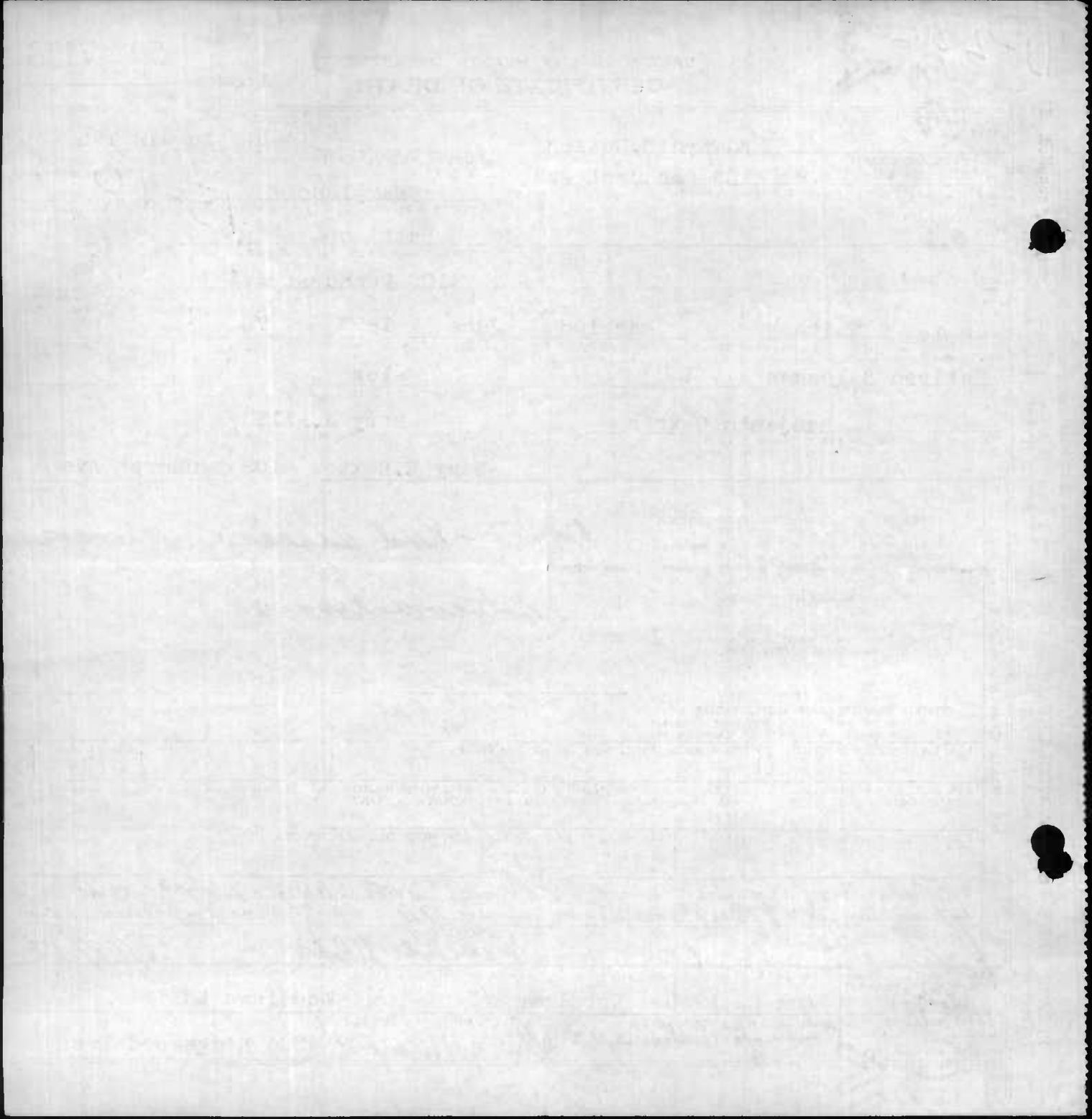
| | | | | | |
|--|--|---|--|---|--|
| 18. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cadio-Red Disease DUE TO Anterior sclerosis DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH Cadio-Red Disease Anterior sclerosis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from June , 19 50 , to Aug 19 , 19 50 , that I last saw the deceased alive on Aug 18 , 19 50 , and that death occurred at 7A m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE L. Emmett Green | | 23B. ADDRESS Med. Bldg. | | 23C. DATE SIGNED 8/19/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug 22 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn | |
| 24D. LOCATION (City, town, or county) Woodlawn Md | | 25. FUNERAL DIRECTOR 4204 Ridgewood Ave | | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1950 | | VS 150 49047 | | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

937



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7159
Registered No.

BIRTH NO. 50 7159

| | | | | | |
|---|------------------------------------|---|---|---|------------------------------|
| 1. NAME OF DECEASED (Type or Print) CONSTANCE JOYNER | | | 2. DATE OF DEATH August 16, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 1318 N. Mount Street | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 12, 1926 | 9. AGE (In years last birthday) 24 | 10. Under 1 Year Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY Hospital | | 11. BIRTHPLACE (State or foreign country) Balto. Md | |
| 13. FATHER'S NAME Joshua Bridger | | | 14. MOTHER'S MAIDEN NAME Myrtle Smith | | |
| 15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no or unknown) No | | | 16. SOCIAL SECURITY NO. | | |
| | | | 17. INFORMANT Myrtle Smith | | |
| | | | ADDRESS 1318 N. Mount St | | |

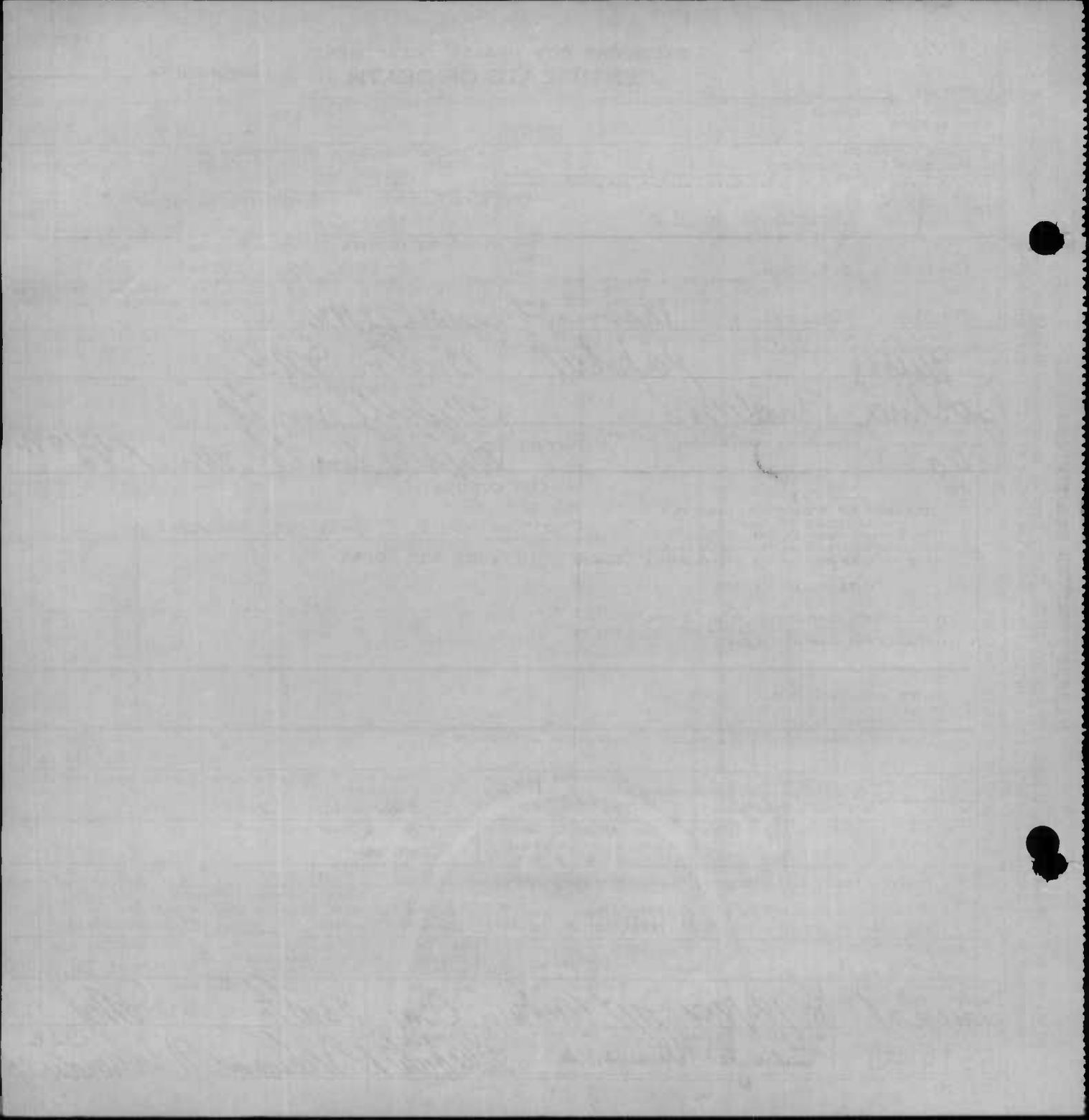
| | | | | | |
|--|--|------------------------------|--|----------------------------------|--|
| 18. E 981 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (A) Bullet wound of chest with penetration | | (B) of lung and aorta | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |

| | | | | | |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1318 N. Mount Street | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Evening | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Firearms | |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | | |
| 23A. SIGNATURE Stanley H. Dunsicker | | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> | | 23C. DATE SIGNED August 16, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-19-1950 | | 24C. NAME OF CEMETERY OR CREMATORY Wt. Auburn Cem | |
| 24D. LOCATION (City, town, or county) (State) Balto Md | | 24E. FUNERAL DIRECTOR Wm. R. Williams | | 24F. ADDRESS 322 | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1950 | | REGISTRAR'S SIGNATURE Wm. R. Williams, M.D. | | | |

V S 151 N-861-4 058 8T 166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Z-120

50 7160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7160

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bertha Johanna Zips

2. DATE
OF
DEATH

Aug 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)

353 S. Bentalou St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 20-05

HOSPITAL OR
INSTITUTION

D. STREET ADDRESS (If rural, give location)

353 S. Bentalou St.

C. Length of stay in Baltimore

34 yrs.

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Oct. 14, 1889

9. AGE (In years
last birthday)

60

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

HOME.

11. BIRTHPLACE (State or foreign country)

AUSTRIA

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Rudolph H. TAMM.

14. MOTHER'S MAIDEN NAME

MARIE TRUMPISCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

John F. Zips

ADDRESS

353 S. Bentalou St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Carcinoma of Breast

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A)
DUE TO(B)
DUE TO(C)
DUE TOOTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK

22. I hereby certify that I attended the deceased from July 1, 1950, to Aug 19, 1950, that I last saw the deceased alive on Aug 18, 1950 and that death occurred at 9:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Albert Scagnetti

23B. ADDRESS

1729 W. Lombard St. 8/19/50

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8-23-50

24C. NAME OF CEMETERY OR CREMATORY

St. Joseph's Cemetery

24D. LOCATION (City, town, or county)

Johnstown Penn.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 20 1950

William M. ...

GEO. L. Schwab 2101 Frederick Ave

VS 150

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WV-320
50 7161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7161
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEOLA WOODS

2. DATE
OF DEATH

AUG 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MD

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 19-02

D. STREET ADDRESS (If rural, give location)

1614 W. FAYETTE ST.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 12, 1900

9. AGE (In years last birthday)

50

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chemical Co.

10B. KIND OF BUSINESS OR INDUSTRY

Factory Labor

11. BIRTHPLACE (State or foreign country)

Shelby N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Cam. Lipscomb

14. MOTHER'S MAIDEN NAME

Hortie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Odessa Black Fayette St.

18. 443X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EDEMA

OR

BRONCHIAL ASTHMA

(B) HYPERTENSIVE C.V.D.

OR

PERITONSILLAR ABSCESS

(C) LUDWIG'S ANGINA

INTERVAL BETWEEN ONSET AND DEATH

12 HRJ

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 12, 1950, to Aug 18, 1950, that I last saw the deceased alive on Aug 18, 1950, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Edmund B. Middleton

M.O.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

Aug 18, 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Shipped
DATE RECEIVED BY LOCAL REGISTRAR
UG 20 1950

24B. DATE

8-19-1950

24C. NAME OF CEMETERY OR CREMATORY

Shelby N.C.

24D. LOCATION (City, town, or county)

Shelby N.C.

(State)

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams

ADDRESS

3224 Schroeder

VS 150

6904R

115D

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Of the ^{several} causes listed, which
in your opinion, was the
underlying cause of death?

"H.C.V.D."

See document FBI 50-7161

9.7.50

EW

E-524
50 7162BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7162
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)RUTH ENGELMAN (Mrs. W^m H.)2. DATE
OF
DEATH

8/18/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

12-02

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3333 N. Charles St. (Charles St.)

5. SEX

F.

W.

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 26 1900

9. AGE (In years last birthday)

38

10 Under 1 Year
Months: Days Hours: Min.

11 Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John P. Steinbach

14. MOTHER'S MAIDEN NAME

Catherine Eliz. Newhar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

W^m H. Engelman 3333 N. Charles St.

18.

416X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Rheumatic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 14, 1950, to Aug 18, 1950, that I last saw the deceased alive on Aug 18, 1950, and that death occurred at 7:52 pm., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

8/20/50

24C. NAME OF CEMETERY OR CREMATORY

Lathron

24D. LOCATION (City, town, or county)

Brooklyn N. Y.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

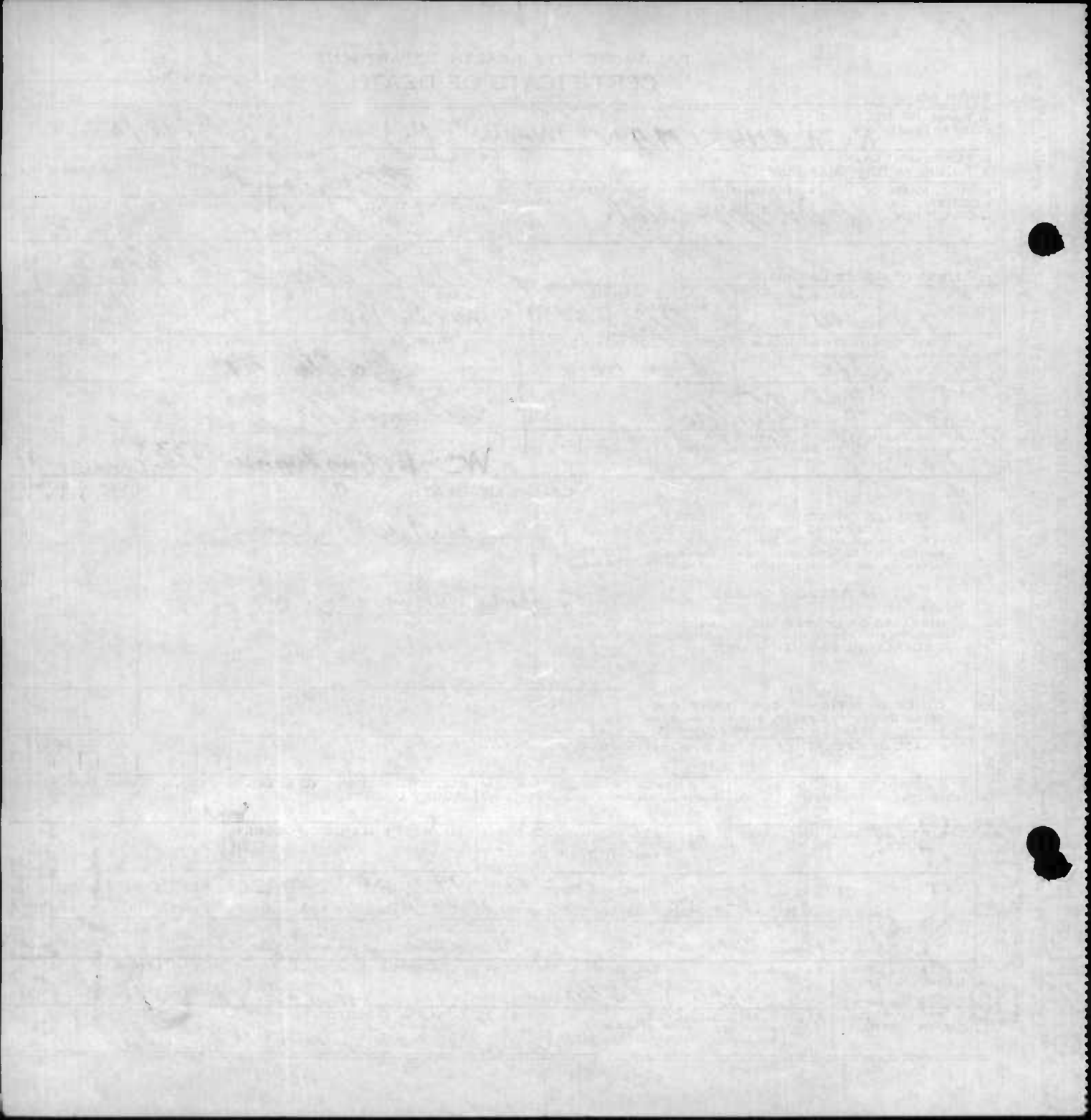
1219 St. Paul St.

AUG 20 1950

95B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

| | | | | | |
|---------------------------|--|-----------------------|--|----------------------|--|
| Name of Animal | | Sex | | Age | |
| Breed | | Color | | Markings | |
| Date of Birth | | Date of Examination | | Place of Birth | |
| Owner's Name | | Address | | City | |
| State | | County | | Zip | |
| Purpose of Examination | | Result of Examination | | Remarks | |
| Signature of Veterinarian | | Signature of Owner | | Signature of Witness | |
| Date of Signature | | Date of Signature | | Date of Signature | |

R-3504 7164

50 7164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

HUGH SIMMS RIDGELY

2. DATE
OF
DEATH

Aug. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4118 Forest Park Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4118 Forest Park Ave.

15-10

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

Advertising

8. DATE OF BIRTH

Aug. 15, 1879

9. AGE (In years last birthday)

71

11. BIRTHPLACE (State or foreign country)

Harford Co. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles A. Ridgely

14. MOTHER'S MAIDEN NAME

Mollie McDow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Helen Ridgely 4118 Forest Park Ave.

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

(A) Coronary Thrombosis

2 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Arteriosclerosis

3-4 years

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 1940, 1950 to Aug 16 1950 that I last saw the deceased alive on Aug 16 1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

D. C. Smith M. D.

23B. ADDRESS

4509 Belknap Ave

23C. DATE SIGNED

Aug 19

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 20 1950

Huntington Williams, M.D.

Wm. J. Zickner, Sons Inc. Belts, Md.

VS 150

00080 6 3

94a

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SARAH (SALLIE) E. WILSON

2. DATE

OF DEATH Aug. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 201 N. Monroe St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

201 N. Monroe St.

B. FULL NAME OF HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 23, 1880

9. AGE (In years last birthday)

69

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Ashley

14. MOTHER'S MAIDEN NAME

Anna Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-07-2499 B

17. INFORMANT

ADDRESS

Mr. Robert E. Wilson 201 N. Monroe St.

18.

760X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Chronic myocarditis, Chronic nephritis

3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Diabetes Mellitus

5 yrs

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 2, 1950, to Aug 17, 1950, that I last saw the deceased alive on Aug 17, 1950, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Harry Ashman

M. D.

23B. ADDRESS

1921 W North Ave

23C. DATE SIGNED

8/18/50.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Mem. Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Tuckner & Sons Inc

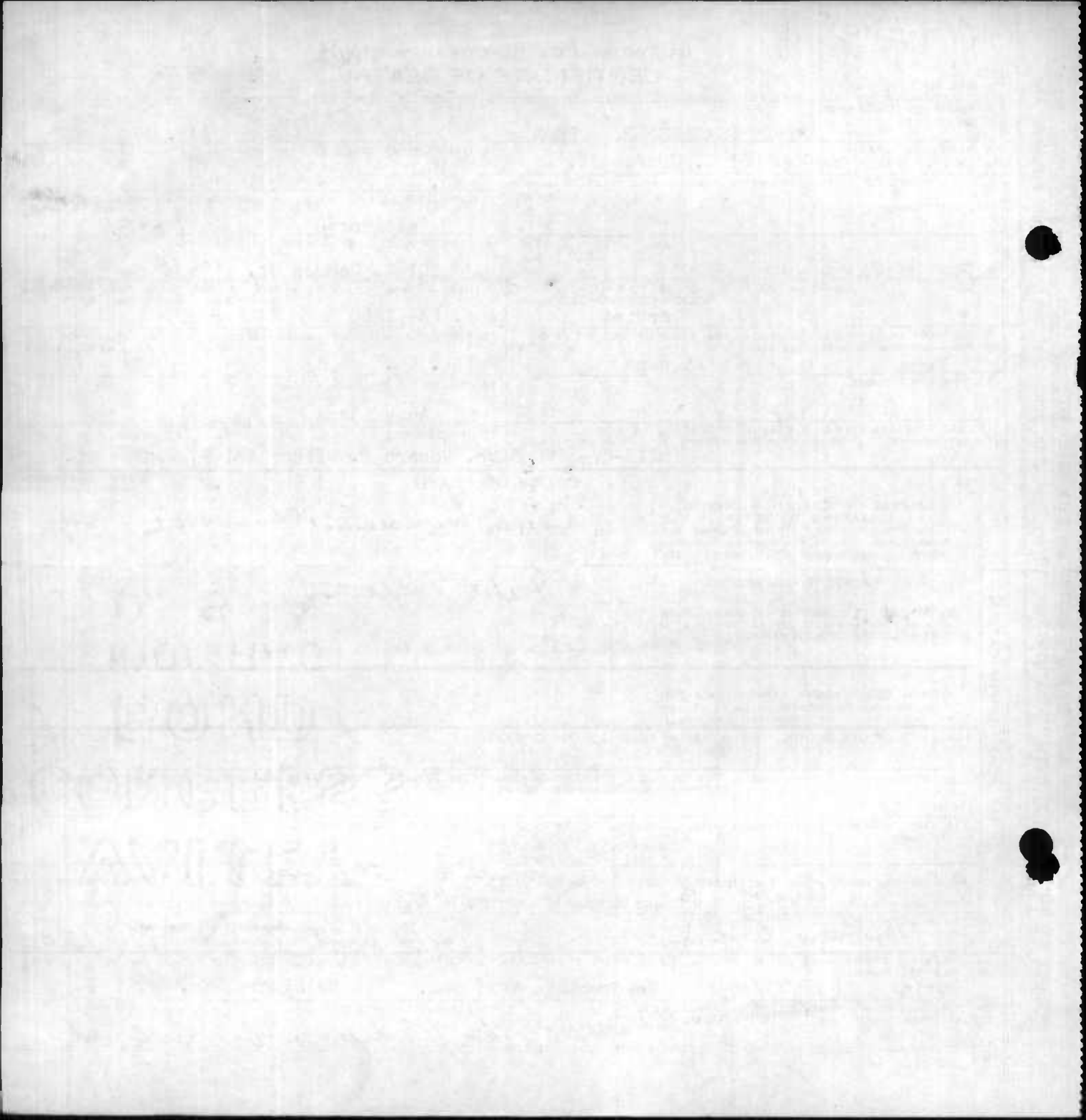
25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tuckner & Sons Inc Balto Md

AUG 20 1950

VS 150



T-520
50 7166BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7166
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE T. THOMAS

2. DATE
OF
DEATH

8-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

9-03

C. Length of stay in Baltimore

20 Yrs.

D. STREET ADDRESS (If rural, give location)

1303 East 36th St.

5. SEX

m

6. COLOR OR RACE

w

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug. 22, 1889

9. AGE (In years
last birthday)

60

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

accountant

10B. KIND OF BUSINESS OR
INDUSTRY

B & O. R. R.

11. BIRTHPLACE (State or foreign country)

Indiana

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John S. Thomas

14. MOTHER'S MAIDEN NAME

Sarah Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, do or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

705-09-0407

17. INFORMANT

ADDRESS

Mrs. Bessie O. Thomas 1303 E. 36th St.

18.

5870

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) UREMIA

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

15 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) LOWER NEPHRON NEPHROSIS

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

ACUTE PANCREATITIS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from Aug 3, 1950, to Aug. 18, 1950, that I last saw the
deceased alive on Aug. 18, 1950, and that death occurred at 4:40 pm., from the causes and on the date stated above.

23A. SIGNATURE

Francis H. Wate

23B. ADDRESS

M. D. Union Memorial Hosp.

23C. DATE SIGNED

8-18-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tucker, Inc. Inc. North & Pa

AUG 23 1950

000 50

128

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATEMENT OF DEATH

1. Name of deceased: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Date of death: [illegible]
5. Place of death: [illegible]
6. Cause of death: [illegible]
7. Signature of declarant: [illegible]
8. Date of statement: [illegible]

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|----------------------------------|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Thomas Madison Parker | | | 2. DATE OF DEATH Aug 18, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY _____ | | |
| B. FULL NAME OF (if not in hospital or institution, give street address or location) 3315 Elmora Ave | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| C. Length of stay in Baltimore 40 yrs | | | D. STREET ADDRESS (If rural, give location) 3315 Elmora Ave | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Sept 1, 1887 | | 9. AGE (In years last birthday) 62 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith | | 10B. KIND OF BUSINESS OR INDUSTRY City of Balto | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Charles Parker | | | 14. MOTHER'S MAIDEN NAME Loannie Wetzel | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Wasa L Parker 3315 Elmora Ave | |

18. **420.0**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

arteriosclerotic Heart Disease - Coronary Sclerosis
Gen' arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

| | | | | | |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION _____ | | 19B. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? * | |
| 22. I hereby certify that I attended the deceased from 8/18 , 19 50 , to 8/18 , 19 50 , that I last saw the deceased alive on _____ 19____, and that death occurred at 11:00 P. M. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Donald W. Mintz | | 23B. ADDRESS 309 E. Regency Ave | | 23C. DATE SIGNED 8/19/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-21-50 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | |
| 24D. LOCATION (City, town, or county) Balto. City | | 24E. LOCATION (State) Balto. City | | 25. FUNERAL DIRECTOR ADDRESS Howard H. Hurlbald 2503 Edmondson | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS Howard H. Hurlbald 2503 Edmondson | |

VS 150

*** - Pt. had been under Dr. Milton C. Lang's care. 937 Ave**
for several years. 50/93

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

THE UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE

1-1

IN SENATE

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THAT

DO

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COMMISSION

OF

THE

UNITED STATES

OF JUSTICE

DO

HEREBY

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50 7168

50 7168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

| | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|--|
| BIRTH NO. _____ | | | 1. NAME OF DECEASED (Type or Print) Rose Huneke | | | 2. DATE OF DEATH August 18, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ | | | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6, 76-02 | | | | | |
| c. Length of stay in Baltimore Life | | | D. STREET ADDRESS (If rural, give location) 1804 Althea Ave., | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug 11 1908 | 9. AGE (In years last birthday) 42 | 10. Under 1 Year Months: _____ Days: _____ | 11. Under 24 Hours Hours: _____ Min: _____ | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwfe. | | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | | 11. BIRTHPLACE (State or foreign country) Baltimore | | |
| 13. FATHER'S NAME John Zanelotti | | | 14. MOTHER'S MAIDEN NAME Lucy Anselmi | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | | 16. SOCIAL SECURITY NO. None | | | 17. INFORMANT ADDRESS Charles W. Huneke 4804 Althea Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary tuberculosis, advanced | | | CAUSE OF DEATH (A) Pulmonary tuberculosis, advanced DUE TO _____ (B) _____ DUE TO _____ (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | |
| 19A. DATE OF OPERATION D | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I hereby certify that I attended the deceased from August 10, 1950 to August 18, 1950 , that I last saw the deceased alive on August 18, 1950 , and that death occurred at 2:20 P.m. , from the causes and on the date stated above. | | | | | | | | |
| 23A. SIGNATURE Thaddeus Siwinski | | | 23B. ADDRESS 1100 N. Caroline St., | | 23C. DATE SIGNED 8/18/50 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug 21-50 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Belair Rd. Balto. 6 Md | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1950 | | REGISTRAR'S SIGNATURE William Williams, M.D. | | 25. FUNERAL DIRECTOR Dignel Bros. 1800 E. Lombard St. | | ADDRESS | | |

VS 150

13B

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-200

50 7169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7169

Registered No.

BIRTH NO. 50-19235

1. NAME OF DECEASED
(Type or Print)

BABY BOY HACK

2. DATE
OF
DEATH

8/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE Where deceased lived, if institution: residence
A. STATE B. COUNTY

Md

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

46 LUTHERAN HOSPITAL OF MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 9-03

c. Length of stay in Baltimore

1 DAY

D. STREET ADDRESS (If rural, give location)

3409 Greenmount Ave

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

8/17/50

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days
11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Simon

14. MOTHER'S MAIDEN NAME

Goldie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Simon Hack - Daniel

18. 762.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pulmonary Abscesses, bilateral

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 8/17, 1950, to 8/18, 1950, that I last saw the
deceased alive on 8/18, 1950, and that death occurred at 11:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Daniel L. Silverstein

23B. ADDRESS

Lutheran Hosp. of Md.

23C. DATE SIGNED

8/20/50

24A. BURIAL, CREMA-
TION (Specify)

24B. DATE

8-20-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county) (State)

Balto Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

M. Williams

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewis Inc 2100 Eutaw Pl

AUG 20 1950

VS 150

161a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Birth | |
| Sex | | Race | |
| Marital Status | | Place of Birth | |
| Occupation | | Cause of Death | |
| Time of Death | | Place of Death | |
| Signature of Physician | | Signature of Registrar | |
| Date of Death | | Place of Death | |

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7170
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

VIOLA

HARRIS

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE
Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

424 Worsley Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

424 Worsley Street

C. Length of stay in Baltimore

35 yrs

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

10-22-1905

9. AGE (In years
last birthday)

45

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work (one during most of working life, even if retired))

House Wife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

P Brown

14. MOTHER'S MAIDEN NAME

Margaret Blueford

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Margaret Blueford 424 Worsley St

18. 4434

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Sanders

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....23C. DATE SIGNED
8-17-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-20-1950

24C. NAME OF CEMETERY OR CREMATORY

Pleasant Rest

24D. LOCATION (City, town, or county) (State)

Towson. Balto Co. Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William V. Sanders, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Rayner Sanders 937
1412 E. Preston St

AUG 20 1950

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]

11-22-1902

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

S-455
50 7171Schleuning
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7171

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Schleuning

2. DATE
OF
DEATH

8/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
location)

South Baltimore General Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give
township)

8-03

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1215 Linwood Avenue N.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 10

9. AGE (In years
last birthday)

33

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR
INDUSTRY

Lever Bros.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ernest Schleuning

14. MOTHER'S MAIDEN NAME

Martha Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 592X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Chronic Glomerulo-nephritis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

Hypertensive Cardiac Vascular

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardiac Vascular disease

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/14, 1950, to 8/18, 1950 that I last saw the
deceased alive on 8/18, 1950 and that death occurred at 11:15 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. C. D. Quirino

23B. ADDRESS

M. D. 1213 Light Street

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-21-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Rosary

24D. LOCATION (City, town, or county) (State)

Baltimore

ADDRESS

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Lilly & Zeiler, 403 S. Wolfe Street

UG 20 1950

VS 150

5544R

131B

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEPT. OF JUSTICE
WASHINGTON, D. C.

RECEIVED

U. S. DEPT. OF JUSTICE
WASHINGTON, D. C.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7172
Registered No. _____

BIRTH NO. 50 7172

| | | | | | |
|--|------------------------------|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) Fredericka S chupple | | | 2. DATE OF DEATH 8-18-50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 506 S. Kenwood Avenue | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. 1-03 | | |
| c. Length of stay in Baltimore Life Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 506 S. Kenwood Avenue | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH June 3-71 | | 9. AGE (In years last birthday) 79 If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME James Diggs | | | 14. MOTHER'S MAIDEN NAME Catherine | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Chas. H. Schupple 506 S. Kenwood Ave | | |

| | | |
|---|--|----------------------------------|
| 18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis DUE TO _____ | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____ (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from June 1940 to Aug 18, 1950 , that I last saw the deceased alive on Aug 17, 1950 , and that death occurred at 4 A. m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE August Zeiler | | 23B. ADDRESS 2739 Eastern Ave | | 23C. DATE SIGNED 8/18/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-21-50 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1950 | | REGISTRAR'S SIGNATURE Antony Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler, 403 S. Wolfe Street. | |

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

8-15-50

Telephone 3-0000

1st Floor

Baltimore, Md.

500 S. Kennwood Avenue

500 S. Kennwood Avenue

1st

June 1-77

1st Floor

Use

1st Floor

1st Floor

1st Floor

1st Floor

500 S. Kennwood Ave

1st Floor

1st Floor

1st Floor

1st Floor

500 S. Kennwood Ave

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7173

BIRTH NO. 463

1. NAME OF DECEASED
(Type or Print)

Elizabeth Dilworth

2. DATE
OF
DEATH

Aug. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, or institution: residence

A. STATE

B. COUNTY

before admission)

Md.

Anne Arundel

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Orchard Beach

D. STREET ADDRESS (If rural, give location)

5200

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

5-9-1885

9. AGE (In years

last birthday)

65

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None.

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Arteriosclerotic Cardio-
Vascular Disease

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from
Autopsy, inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer J.

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

Aug. 19, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

B.

24B. DATE

J. 12-50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

BALTIMORE

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Therese Williams, M.D.

25. FUNERAL DIRECTOR

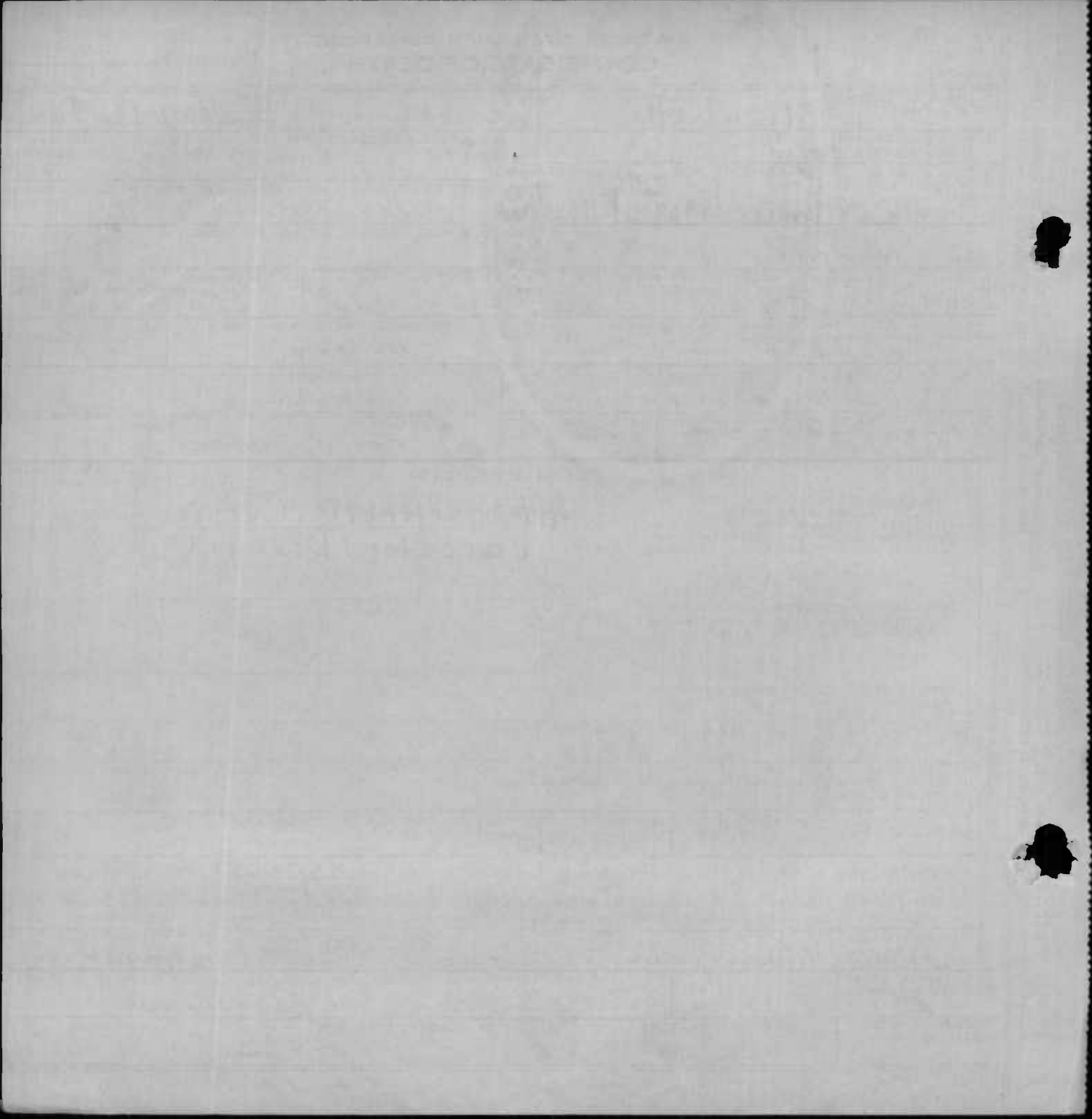
ADDRESS

James L. Lee

100 E. Front St.

93D

VS 451

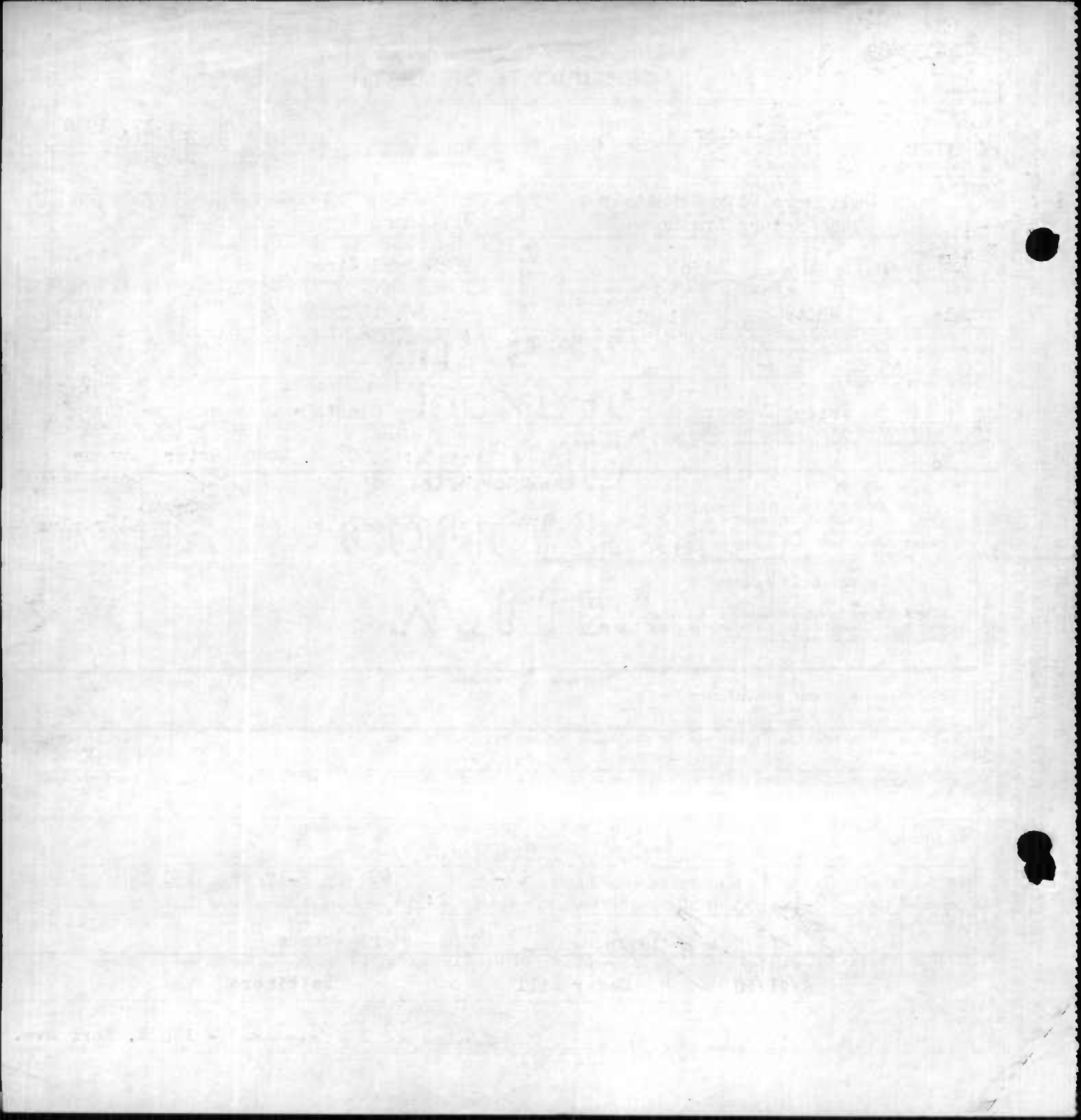


L-260
REA-133289BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

| | | | |
|---|--|---|--|
| BIRTH NO. 50 7174 | | 2. DATE OF DEATH August 17, 1950 | |
| 1. NAME OF DECEASED (Type or Print) Frank Lacher | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 14940 Eastern Avenue | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-04 | |
| c. Length of stay in Baltimore Life Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 1828 Byrd Street | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH Sept. 26, 1882 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 67 |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Joseph Lacher | | 14. MOTHER'S MAIDEN NAME Mary Minsta | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |
| 18. 002X I CAUSE OF DEATH | | Recordas: B. C. H. 4940 Eastern Avenue | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | INTERVAL BETWEEN ONSET AND DEATH | |
| (A) Pulmonary Tuberculosis | | 1yr. plus | |
| DUE TO | | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | |
| | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 11-8, 1949, to 8-17, 1950, that I last saw the deceased alive on 8-17, 1950, and that death occurred at 2:50 P.M., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE J.S. Poyan M.D. | | 23B. ADDRESS 4940 Eastern Avenue | 23C. DATE SIGNED |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) B | 24B. DATE 8/21/50 | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill | 24D. LOCATION (City, town, or county) (State) Baltimore |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| AUG 20 1950 VS 150 | William Williams, M.D. | James L. Casey | - 130 E. Fort Ave. |

13B



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7175

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Harry Linton

2. DATE
OF
DEATH

August 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland Frederick

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Frederick

c. Length of stay in Baltimore

Just come

D. STREET ADDRESS (If rural, give location)

R.F.D. #2

6000

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 17, 1901

9. AGE (In years last birthday)

49

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Brush Maker

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Frederick, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

FRANK LINTON

14. MOTHER'S MAIDEN NAME

Mary Tyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

214-10-2736

17. INFORMANT

Catherine Linton

ADDRESS

Frederick

18.

163X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma of lung

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 3, 1950, to Aug. 20, 1950, that I last saw the deceased alive on Aug. 20, 1950, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John A. Spittler Jr.

M.D.

23B. ADDRESS

Mercy Hosp.

23C. DATE SIGNED

Aug. 20, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Frederick, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

Aug 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

M.R. Etelson & Sons

ADDRESS

Fred. Md.

CERTIFICATE OF DEATH

Henry J. Carter

General Hospital

West 100th

State of New York

County of New York

City of New York

Dec 10 1910

Attest: J. J. [Signature]

Dec 10 1910

Dec 10 1910

Dec 10 1910

Dec 10 1910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7176

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Emory Arrington

2. DATE
OF
DEATH

8-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

A. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

St. Agnes Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore, Laurel

O. STREET ADDRESS (If rural, give location)

326 Prince Georges St. Laurel

c. Length of stay in Baltimore

7 Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2-14-1889

9. AGE (In years last birthday)

61

10. Under 1 Year Months: Days

6 4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

machinist

10B. KIND OF BUSINESS OR INDUSTRY

Br Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George P. Arrington

14. MOTHER'S MAIDEN NAME

Addie Pratherham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

705-03-9466

17. INFORMANT

Hospital records

ADDRESS

18.

451X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Aneurism

DUE TO Thoracic aorta.

ANTECEDENT CAUSES

(B) Anterio-sclerotic C.V.D.

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-18-50

19B. MAJOR FINDINGS OF OPERATION

Aneurism Thoracic aorta.

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-10-50, 19 to 8-18, 1950, that I last saw the deceased alive on 8-18-50, and that death occurred at 2:30 PM, from the causes and on the date stated above.

23A. SIGNATURE

Arthur T. Hare Jr.

M. O.

23B. ADDRESS

St. Agnes Hosp.

23C. DATE SIGNED

8-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

August 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Ingle Hill Cemetery

24D. LOCATION (City, town, or county)

Laurel, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

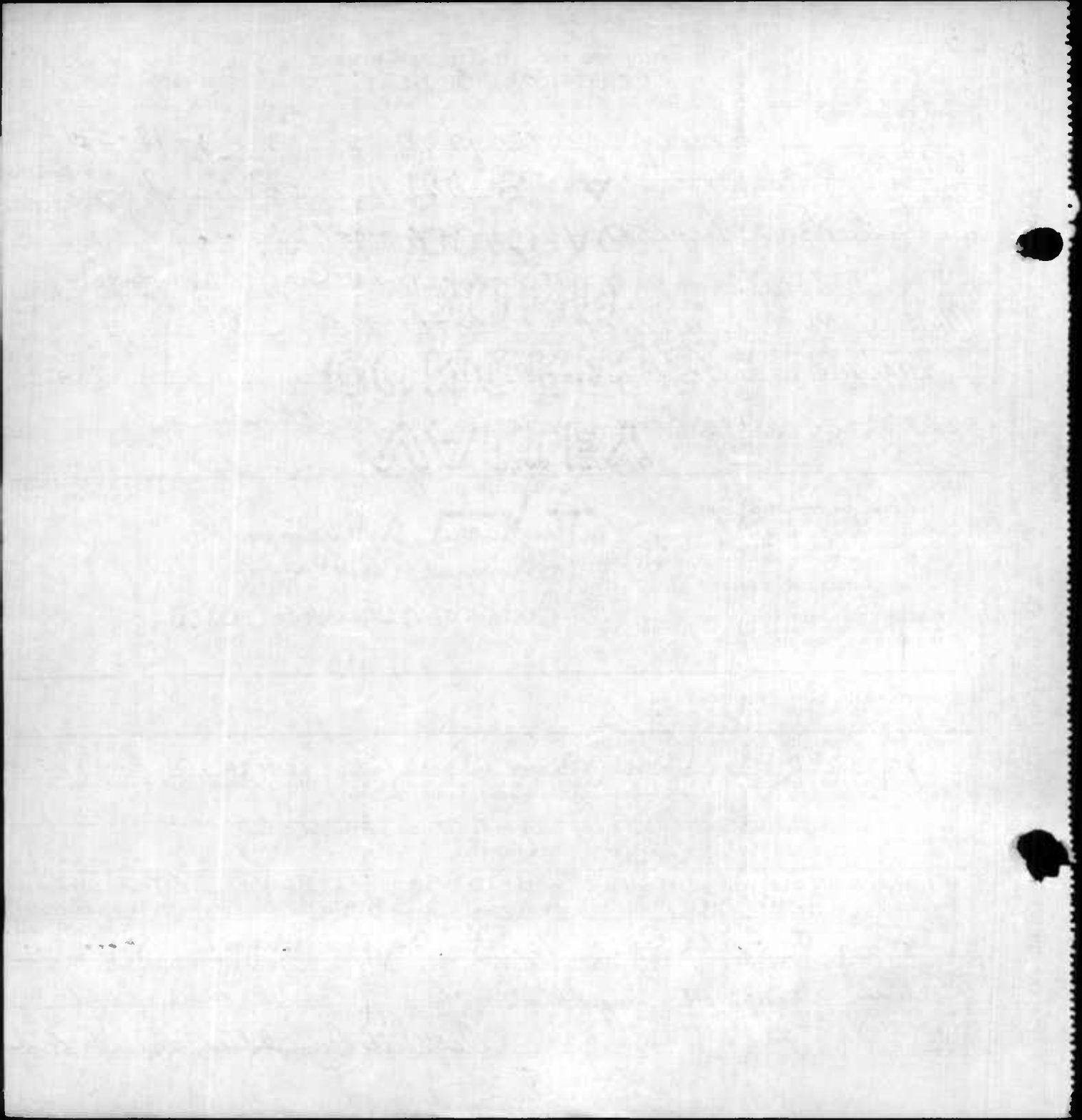
REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

W. W. Donaldson, Laurel, Md.

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7177
Registered No. _____

BIRTH NO. 530 7177

| | | | | | |
|--|----------------------------------|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Owen Carson Smith</i> | | | 2. DATE OF DEATH <i>8/20/50</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> COUNTY <i>Baltimore</i> <i>1525 Eutaw Place</i> | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i> | | | CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> | | |
| C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) <i>1525 Eutaw Place</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>7/27/05</i> | 9. AGE (In years last birthday) <i>45</i> | 10. Under 1 Year Months: _____ Days: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i> | | |
| 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>Joseph Louisa Smith</i> | | | 14. MOTHER'S MAIDEN NAME <i>Maudie Powell</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) _____ | | | 16. SOCIAL SECURITY NO. _____ | | |
| 17. INFORMANT <i>Hila</i> | | | ADDRESS <i>as above</i> | | |

| | | | |
|---|--|---|----------------------------------|
| 18. <i>023X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| (A) _____ | | <i>Aortic insufficiency</i> | <i>unknown</i> |
| ANTECEDENT CAUSES | | (B) _____ | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | <i>Syphilitic aortitis by clinical impression + past serology</i> | |
| (C) _____ | | <i>Cardiomegaly</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Bronchial pneumonia</i> | |

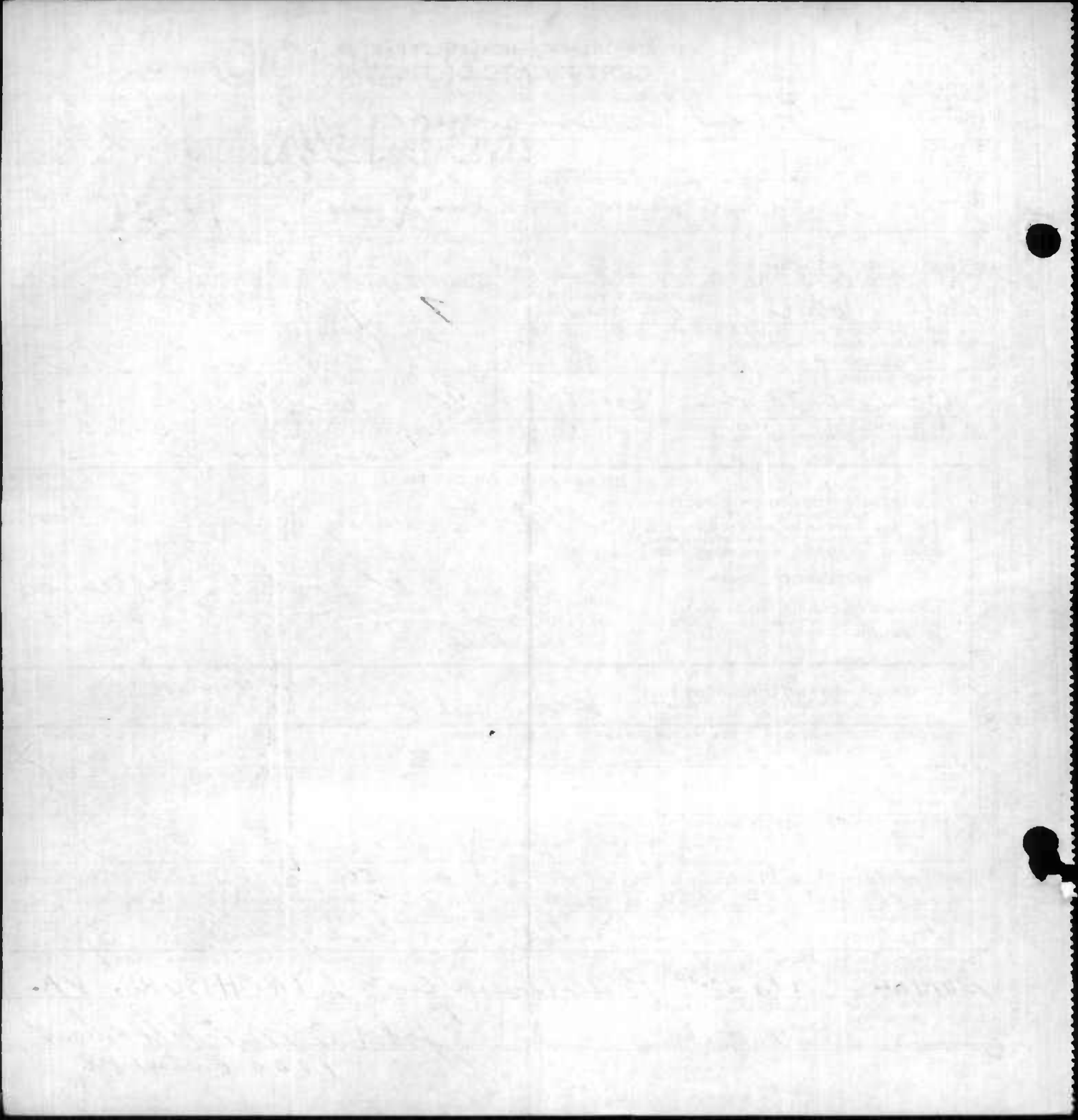
| | | | | |
|--|--|--|--|---|
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <i>6-6, 1950</i> to <i>8-20, 1950</i> , that I last saw the deceased alive on <i>8/20, 1950</i> , and that death occurred at <i>2:30 p.m.</i> , from the causes and on the date stated above. | | | | |
| 23A. SIGNATURE <i>Maryland General Hospital</i> | | 23B. ADDRESS <i>Maryland General Hospital</i> | | 23C. DATE SIGNED <i>8/20/50</i> |

| | | | |
|--|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 24B. DATE <i>AUG 20-50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cemetery</i> | 24D. LOCATION (City, town, or county) (State) <i>LYNCHBURG, VA.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1950</i> | REGISTRAR'S SIGNATURE <i>Huntington Williams, Jr.</i> | | 25. FUNERAL DIRECTOR <i>John O Mitchell & Sons</i> |
| VS 150 | | ADDRESS <i>1900 Eutaw Pl.</i> | |

56424

MARGIN RESERVED FOR BINDING

PLEASE WRITE READILY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 50 7178 | |
|--|---------------------------|--|-----------------------------------|--|----------------------------------|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO. 50-15137 | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| | | Baby Carter | | (2nd.) July 23, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-02 | | | |
| c. Length of stay in Baltimore | | D. STREET ADDRESS (If rural, give location) 3900 Tivoly Avenue | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single | 8. DATE OF BIRTH July 23, 1950 | 9. AGE (In years last birthday) 3 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10B. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? 3 | | 13. FATHER'S NAME Robert Carter | | 14. MOTHER'S MAIDEN NAME Eugenia Nichols | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records | |
| 18. 759.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CONGENITAL MALFORMATION DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO | | CAUSE OF DEATH Congenital malformation | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 23, 1950, to July 23, 1950, that I last saw the deceased alive on July 23, 1950, and that death occurred at 11:40 A., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Louis M. Bellman | | 23B. ADDRESS 601 N. Broadway | | 23C. DATE SIGNED 7-24-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY Holy Sepulchre | |
| 24D. LOCATION (City, town, or county) (State) | | 25. FUNERAL DIRECTOR | | ADDRESS | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1950 | | REGISTRAR'S SIGNATURE Wm. H. Williams, M.D. | | | |

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7179

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LIONEL ALEXANDER

2. DATE
OF
DEATH

August 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

17-01

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

630 Jasper Street

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov. 3, 1929

9. AGE (In years
last birthday)

20

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Furniture Store

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Alexander

14. MOTHER'S MAIDEN NAME

Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

Rott, Ulagrande - James P. Smith

ADDRESS

18. E 982 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Internal hemorrhage

DUE TO stab wound of chest

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)

Linden Avenue and Camel Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 18, 1950 11.45 a.m.

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed with penknife during altercation

22. I certify that I took charge of the remains described above, held an autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

Stanley K. Dunsacker

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 18, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

W. H. Hallett

ADDRESS

- 918 -

VS 151

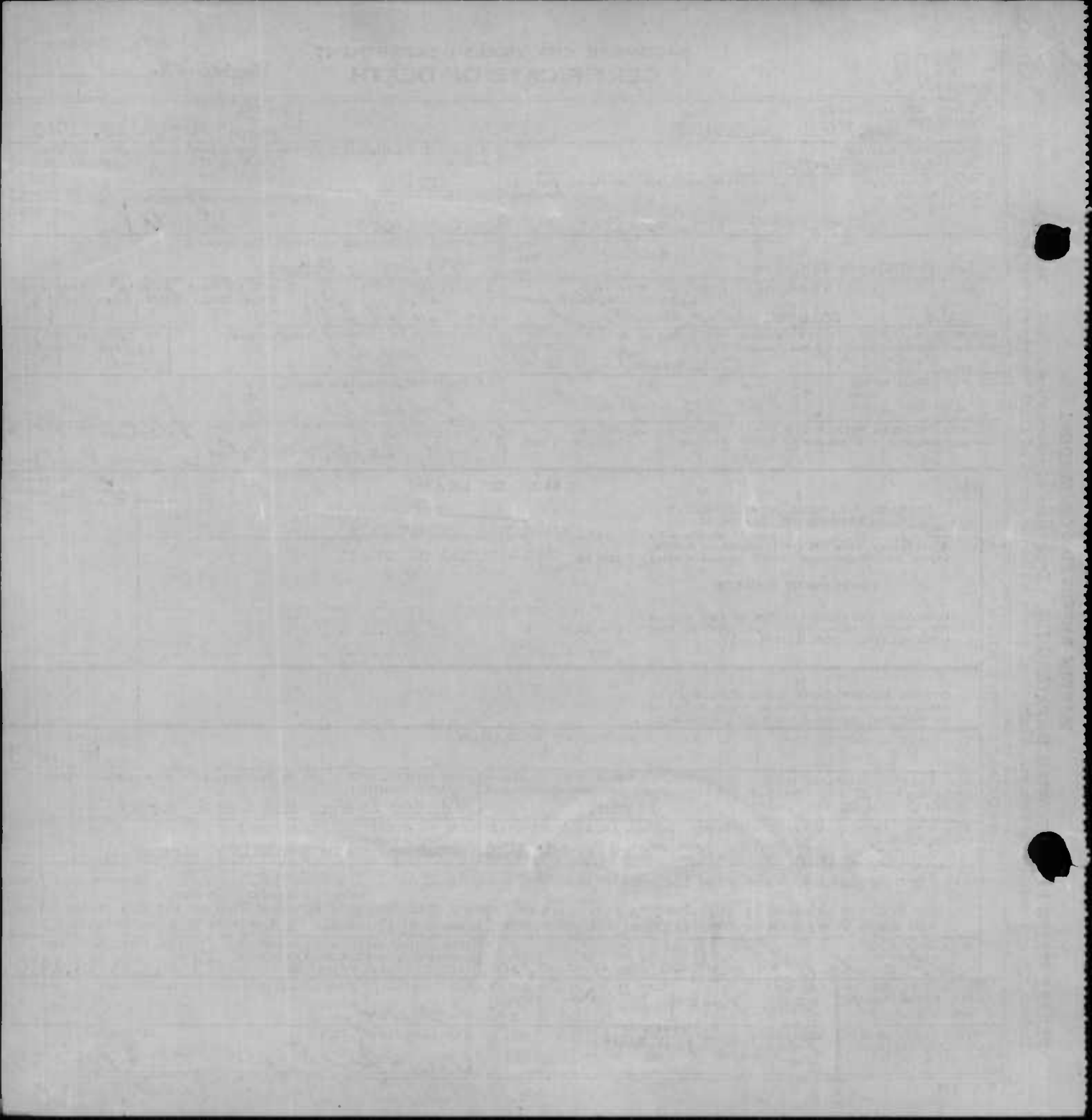
N-862.2

97066

Hallett Hall Ave 167

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7180
Registered No.

BIRTH NO.

| | | | | | |
|---|------------------------------------|---|---|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Bertha B. White Bowser Ringgold</i> | | | 2. DATE OF DEATH <i>Aug 17-1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>907 N. Caroline St</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>7-04</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> | | |
| c. Length of stay in Baltimore <i>Life</i> | | | D. STREET ADDRESS (If rural, give location) <i>907 N. Caroline St</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widower</i> | 8. DATE OF BIRTH <i>1887</i> | 9. AGE (In years last birthday) <i>63</i> | 10. Under 1 Year Months: Days Hours: Min. <i>- - -</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at Home</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>-</i> | | |
| 11. BIRTHPLACE (State or foreign country) <i>Balto</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | |
| 13. FATHER'S NAME <i>Emery White</i> | | | 14. MOTHER'S MAIDEN NAME <i>Laura Hillard</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <i>Harvey White</i> | | | ADDRESS <i>244 N. Monroe St</i> | | |

MARGIN RESERVED FOR BINDING

| | | |
|---|---|----------------------------------|
| 18. <i>442X</i> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | (A) <i>Pulmonary Edema</i> | <i>24 hrs.</i> |
| ANTECEDENT CAUSES | (B) <i>Myocardial & Renal Insufficiency</i> | <i>(History) 6 mos.</i> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (C) <i>Hypertension</i> | <i>?</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

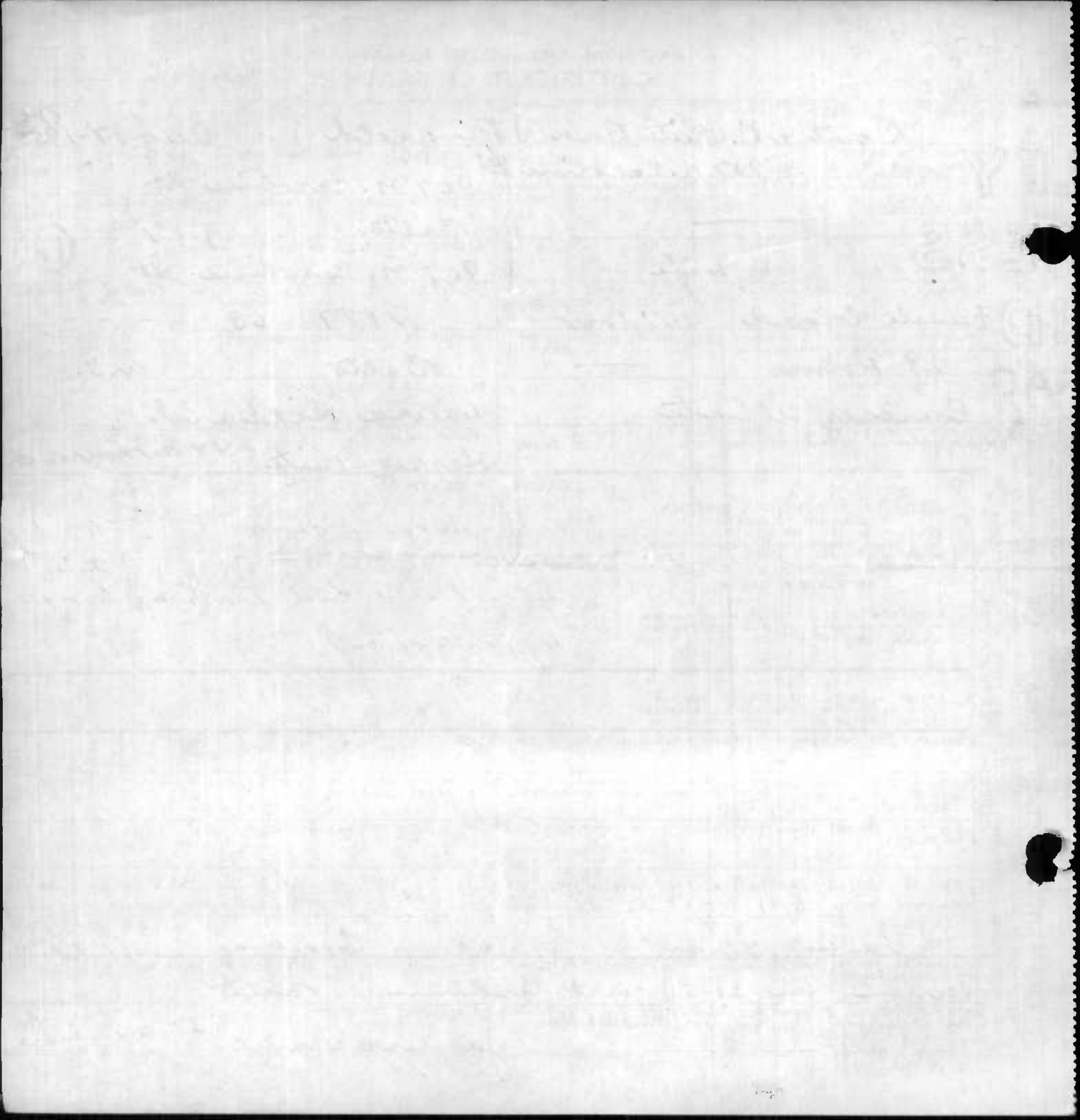
| | | | | | |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>8/17</i> , 1950, to <i>8/17</i> , 1950, that I last saw the deceased alive on <i>8/17</i> , 1950, and that death occurred at <i>9:40</i> p. m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>J. Preston Grant</i> | | 23B. ADDRESS <i>601 N. Carrollton</i> | | 23C. DATE SIGNED <i>8/19/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Aug 21-50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>mt. Auburn</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Balto</i> | | 25. FUNERAL DIRECTOR <i>James A. Stays</i> | | | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1950</i> | | REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i> | | ADDRESS <i>638 N. Gilman St</i> | |

VS 150

937

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7181

P-430
50 7181

| | | | | | |
|---|------------------|--|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| | | WM F. PIITT | | 8/19/50 | |
| 3. PLACE OF DEATH: | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | 5. STATE | |
| A. Baltimore City, Maryland | | 4101 W Overlea Ave Balto, Co. MD | | B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION | | C. CITY OR TOWN | | D. STREET ADDRESS (If rural, give location) | |
| 207 E. Highfield Rd. | | Balto. Co | | 4101 W Overlea Ave | |
| C. Length of stay in Baltimore | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| 9- Mos. Days | | Sept. 23 rd 1884 | | 65 | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 11. BIRTHPLACE (State or foreign country) | | |
| M | W | Married | Baltimore City MD | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 12. CITIZEN OF WHAT COUNTRY? | | |
| Nurse | | Private Nurse | AMERICAN | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Fred PIITT | | Elizabeth W. WYKESMAN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | NO | | Mrs W F PIITT | |
| | | | | ADDRESS | |
| | | | | 4104 W Overlea Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | (A) Coronary Thrombosis | | 8/19/50 | |
| | | DUE TO arterial - sclerosis - (anginal attack) | | June 2/50 | |
| | | (B) arterial Hypertension - | | | |
| | | DUE TO | | | |
| 19. ANTECEDENT CAUSES | | (C) Diabetes Mellitus | | 2 year | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | |
| 0 | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I hereby certify that I attended the deceased from June 2, 1950, to Aug 19, 1950, that I last saw the deceased alive on Aug 12, 1950, and that death occurred at 7:30 A.M., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE | | 23B. ADDRESS | | 23C. DATE SIGNED | |
| Louis R. Krenn | | 722 W. Kenwood Ave | | Aug 19/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Aug-22-1950 | | Baltimore-Cemetery | |
| DATE RECEIVED BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR | |
| AUG 21 1950 | | William Williams, M.D. | | Lassahn-Funeral-Home | |
| | | | | ADDRESS | |
| | | | | 7401 Belair Rd. | |

Trunee 122 1/2 Kurood are

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

E-166
50 7182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7182

| | | | | | |
|---|----------------------------------|--|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) William Eberhart | | 2. DATE OF DEATH Aug. 18, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 2012 N. Forest Park Ave., 66-- Yrs. Mos. Days | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| c. Length of stay in Baltimore | | D. STREET ADDRESS (If rural, give location) 2012 N. Forest Park Ave., | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug. 14, 1884 | 9. AGE (In years last birthday) 66 | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Confectionery Business | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME John Eberhart | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mrs. Clara S. Eberhart 2012 N. Forest Park Ave. | |
| 18. 420.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Angina Pectoris Indist 2 year duration DUE TO Antecedent Causes Acute Schlemia 5 years DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH Angina Pectoris Indist 2 year duration Acute Schlemia 5 years | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 1947 , 1950 to Aug 18, 1950 that I last saw the deceased alive on Aug 17, 1950 and that death occurred at 6:30 A. m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE A. C. Smith | | 23B. ADDRESS 4509 Liberty Hgts | | 23C. DATE SIGNED Aug 19 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-21-1950 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave., | |
| VS 150 | | 2906A | | 94B | |

D. L. L. L.

1509 Lib. H. Ave.

1509 Lib. H. Ave.
D. L. L. L.

1509 Lib. H. Ave.

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1509 Lib. H. Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7183BIRTH NO. 3241. NAME OF DECEASED
(Type or Print) Bessie E. Mitchell2. DATE OF DEATH Aug, 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1621 Waldo St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore M.D.7-05

D. STREET ADDRESS (If rural, give location)

1621 Waldo St.

c. Length of stay in Baltimore

Life time

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1/20/1889

9. AGE (In years last birthday)

61

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

maid

10B. KIND OF BUSINESS OR INDUSTRY

In Hospital

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Harry Holmes

14. MOTHER'S MAIDEN NAME

Georgiana Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

17. INFORMANT

Webster Mitchell

ADDRESS

1621 Waldo St.18. 444X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Uremia

DUE TO

3 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

4 years

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November, 1949, to August, 1950, that I last saw the deceased alive on August 15, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

R. W. M. Daniel

M. D.

23B. ADDRESS

807 N. Caroline

23C. DATE SIGNED

8-19-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 22, 50

24C. NAME OF CEMETERY OR CREMATORY

Int Ashburn cem

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lottie Gross 1408 Ashland av

3
F.D. 203
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
CERTIFICATE OF DEATH

| | | | |
|---------------------|--|---------------------|--|
| 1. Name of Deceased | | 2. Date of Death | |
| 3. Place of Death | | 4. Cause of Death | |
| 5. Age at Death | | 6. Sex | |
| 7. Race | | 8. Marital Status | |
| 9. Occupation | | 10. Education | |
| 11. Date of Birth | | 12. Date of Death | |
| 13. Place of Birth | | 14. Date of Death | |
| 15. Place of Death | | 16. Cause of Death | |
| 17. Age at Death | | 18. Sex | |
| 19. Race | | 20. Marital Status | |
| 21. Occupation | | 22. Education | |
| 23. Date of Birth | | 24. Date of Death | |
| 25. Place of Birth | | 26. Date of Death | |
| 27. Place of Death | | 28. Cause of Death | |
| 29. Age at Death | | 30. Sex | |
| 31. Race | | 32. Marital Status | |
| 33. Occupation | | 34. Education | |
| 35. Date of Birth | | 36. Date of Death | |
| 37. Place of Birth | | 38. Date of Death | |
| 39. Place of Death | | 40. Cause of Death | |
| 41. Age at Death | | 42. Sex | |
| 43. Race | | 44. Marital Status | |
| 45. Occupation | | 46. Education | |
| 47. Date of Birth | | 48. Date of Death | |
| 49. Place of Birth | | 50. Date of Death | |
| 51. Place of Death | | 52. Cause of Death | |
| 53. Age at Death | | 54. Sex | |
| 55. Race | | 56. Marital Status | |
| 57. Occupation | | 58. Education | |
| 59. Date of Birth | | 60. Date of Death | |
| 61. Place of Birth | | 62. Date of Death | |
| 63. Place of Death | | 64. Cause of Death | |
| 65. Age at Death | | 66. Sex | |
| 67. Race | | 68. Marital Status | |
| 69. Occupation | | 70. Education | |
| 71. Date of Birth | | 72. Date of Death | |
| 73. Place of Birth | | 74. Date of Death | |
| 75. Place of Death | | 76. Cause of Death | |
| 77. Age at Death | | 78. Sex | |
| 79. Race | | 80. Marital Status | |
| 81. Occupation | | 82. Education | |
| 83. Date of Birth | | 84. Date of Death | |
| 85. Place of Birth | | 86. Date of Death | |
| 87. Place of Death | | 88. Cause of Death | |
| 89. Age at Death | | 90. Sex | |
| 91. Race | | 92. Marital Status | |
| 93. Occupation | | 94. Education | |
| 95. Date of Birth | | 96. Date of Death | |
| 97. Place of Birth | | 98. Date of Death | |
| 99. Place of Death | | 100. Cause of Death | |

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7184
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Mildred MINNIS

2. DATE
OF
DEATH

8-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

3111 BARCLAY ST.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

MD

B. COUNTY

12-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give location)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3111 BARCLAY ST.

c. Length of stay in Baltimore

LIFE

5. SEX

F

6. COLOR OR RACE

C.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
MARRIED

8. DATE OF BIRTH

6-9-04

9. AGE (in years last birthday)

46

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

LOUIS HARRISON

14. MOTHER'S MAIDEN NAME

ELEANORE FRANCIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or duties of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
SAMUEL MINNIS 3111 BARCLAY

18. *331X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Accident

1 hour

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Malignant Hypertension

14 months

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Aug 12, 1950*, to *Aug 17, 1950* that I last saw the deceased alive on *Aug 17, 1950*, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

R.W. McDaniel

23B. ADDRESS

807 N. Caroline St.

23C. DATE SIGNED

8-19-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

8-21-50

MT. CALVARY

A.A. COUNTY, MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950

Thurston Williams, M.D.

Joseph C. Locks, Jr. 1304 N. Central

VS 150

7208A

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COINTEGRATION

WALLEN

Richard Wallen
Richard Wallen

1007 545

M-240
50 7185BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7185

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) ALEX MOSELY

2. DATE

OF DEATH August 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

University Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1435 Parrish Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years
last birthday)

62

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

D

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Denecker M.D.

23B. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

August 2, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL AUG 14 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

| No. | | Name | | Origin | | Date | | Remarks | |
|-----|--|------|--|--------|--|------|--|---------|--|
| 1 | | 2 | | 3 | | 4 | | 5 | |
| 2 | | 3 | | 4 | | 5 | | 6 | |
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| 13 | | 14 | | 15 | | 16 | | 17 | |
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| 15 | | 16 | | 17 | | 18 | | 19 | |
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| 21 | | 22 | | 23 | | 24 | | 25 | |
| 22 | | 23 | | 24 | | 25 | | 26 | |
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| 28 | | 29 | | 30 | | 31 | | 32 | |
| 29 | | 30 | | 31 | | 32 | | 33 | |
| 30 | | 31 | | 32 | | 33 | | 34 | |
| 31 | | 32 | | 33 | | 34 | | 35 | |
| 32 | | 33 | | 34 | | 35 | | 36 | |
| 33 | | 34 | | 35 | | 36 | | 37 | |
| 34 | | 35 | | 36 | | 37 | | 38 | |
| 35 | | 36 | | 37 | | 38 | | 39 | |
| 36 | | 37 | | 38 | | 39 | | 40 | |
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| 38 | | 39 | | 40 | | 41 | | 42 | |
| 39 | | 40 | | 41 | | 42 | | 43 | |
| 40 | | 41 | | 42 | | 43 | | 44 | |
| 41 | | 42 | | 43 | | 44 | | 45 | |
| 42 | | 43 | | 44 | | 45 | | 46 | |
| 43 | | 44 | | 45 | | 46 | | 47 | |
| 44 | | 45 | | 46 | | 47 | | 48 | |
| 45 | | 46 | | 47 | | 48 | | 49 | |
| 46 | | 47 | | 48 | | 49 | | 50 | |
| 47 | | 48 | | 49 | | 50 | | 51 | |
| 48 | | 49 | | 50 | | 51 | | 52 | |
| 49 | | 50 | | 51 | | 52 | | 53 | |
| 50 | | 51 | | 52 | | 53 | | 54 | |
| 51 | | 52 | | 53 | | 54 | | 55 | |
| 52 | | 53 | | 54 | | 55 | | 56 | |
| 53 | | 54 | | 55 | | 56 | | 57 | |
| 54 | | 55 | | 56 | | 57 | | 58 | |
| 55 | | 56 | | 57 | | 58 | | 59 | |
| 56 | | 57 | | 58 | | 59 | | 60 | |
| 57 | | 58 | | 59 | | 60 | | 61 | |
| 58 | | 59 | | 60 | | 61 | | 62 | |
| 59 | | 60 | | 61 | | 62 | | 63 | |
| 60 | | 61 | | 62 | | 63 | | 64 | |
| 61 | | 62 | | 63 | | 64 | | 65 | |
| 62 | | 63 | | 64 | | 65 | | 66 | |
| 63 | | 64 | | 65 | | 66 | | 67 | |
| 64 | | 65 | | 66 | | 67 | | 68 | |
| 65 | | 66 | | 67 | | 68 | | 69 | |
| 66 | | 67 | | 68 | | 69 | | 70 | |
| 67 | | 68 | | 69 | | 70 | | 71 | |
| 68 | | 69 | | 70 | | 71 | | 72 | |
| 69 | | 70 | | 71 | | 72 | | 73 | |
| 70 | | 71 | | 72 | | 73 | | 74 | |
| 71 | | 72 | | 73 | | 74 | | 75 | |
| 72 | | 73 | | 74 | | 75 | | 76 | |
| 73 | | 74 | | 75 | | 76 | | 77 | |
| 74 | | 75 | | 76 | | 77 | | 78 | |
| 75 | | 76 | | 77 | | 78 | | 79 | |
| 76 | | 77 | | 78 | | 79 | | 80 | |
| 77 | | 78 | | 79 | | 80 | | 81 | |
| 78 | | 79 | | 80 | | 81 | | 82 | |
| 79 | | 80 | | 81 | | 82 | | 83 | |
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| 81 | | 82 | | 83 | | 84 | | 85 | |
| 82 | | 83 | | 84 | | 85 | | 86 | |
| 83 | | 84 | | 85 | | 86 | | 87 | |
| 84 | | 85 | | 86 | | 87 | | 88 | |
| 85 | | 86 | | 87 | | 88 | | 89 | |
| 86 | | 87 | | 88 | | 89 | | 90 | |
| 87 | | 88 | | 89 | | 90 | | 91 | |
| 88 | | 89 | | 90 | | 91 | | 92 | |
| 89 | | 90 | | 91 | | 92 | | 93 | |
| 90 | | 91 | | 92 | | 93 | | 94 | |
| 91 | | 92 | | 93 | | 94 | | 95 | |
| 92 | | 93 | | 94 | | 95 | | 96 | |
| 93 | | 94 | | 95 | | 96 | | 97 | |
| 94 | | 95 | | 96 | | 97 | | 98 | |
| 95 | | 96 | | 97 | | 98 | | 99 | |
| 96 | | 97 | | 98 | | 99 | | 100 | |

RECEIVED BY THE BUREAU OF PLANT INDUSTRY

1911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED

(Type or Print) WILLIAM STAHL

2. DATE
OF
DEATH

July 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

South Baltimore General Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

4-02

D. STREET ADDRESS (If rural, give location)

611 W. Baltimore Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

N

9. AGE (In years
last birthday)

52

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

N

K

11. BIRTHPLACE (State or foreign country)

N

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

W

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. 581.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty degeneration of liver

DUE TO chronic alcoholism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Dineen, M.D.

23B. CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

July 20, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL AUG 14 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950

Huntington Williams, M.D.

Commissioner of Health

VS 151

124a ✓

BALLAHAN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7187

BIRTH NO. 50-16860

1. NAME OF DECEASED
(Type or Print) Baby Girl Callahan

2. DATE OF DEATH 8-10-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY MD

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1813 ASHBURTON ST.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

LUTHERAN HOSPITAL OF MD. INC.

BALTIMORE MD 15-06

46
c. Length of stay in Baltimore 1 ^{Wks.} _{Days}

D. STREET ADDRESS (If rural, give location)

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8-9-50

9. AGE (In years last birthday)

10 Under 1 Year
Months Days

11 Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

CHARLES BALLAHAN

14. MOTHER'S MAIDEN NAME

BETTY JANE HAMM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 76 yr. 5

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary atelectasis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Premature birth

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-9-, 1950, to 8-10, 1950, that I last saw the deceased alive on 8-10, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Jerome Guber

M. D.

23B. ADDRESS

Lutheran Hosp.

23C. DATE SIGNED

8-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

AUG 21 1950

VS 150

JOHN HOPKINS MEDICAL SCHOOL AUG 16 1950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7188

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

BROWNLEY

MEREDITH

2. DATE
OF
DEATH

August 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1132 N. Gilmore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE Maryland B. COUNTY before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1132 N. Gilmore Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
single

8. DATE OF BIRTH

May 24, 1946

9. AGE (In years
last birthday)

4

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Norman Meredith

14. MOTHER'S MAIDEN NAME

Helen Brownley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Helen Meredith 1132 N. Gilmore St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Acute tonsillitis

(C) Bilateral otitis media

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS* CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Durlacher M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 19, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
burial

24B. DATE

Aug. 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

V. B. Durlacher, M.D.

25. FUNERAL DIRECTOR

7a Brooks

ADDRESS

1463 N. Carey

107

STATE OF NEW YORK
OFFICE OF THE COMMISSIONER OF DEATH

DEATH CERTIFICATE

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

TIME OF BURIAL

TIME OF CREMATION

TIME OF INTERMENT

TIME OF EXHUMATION

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

TIME OF REINTERMENT

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7189

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CATHERINE M. Smith

2. DATE
OF
DEATH

Aug. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

Baltimore

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

Lutheran Hospital of Md.

C. CITY OR TOWN (If outside corporate limits, write FULL and give
township)

Baltimore

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

2850 W. Lanvale St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11/2/1880

9. AGE (In years
last birthday)

69

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George F. Gemp

14. MOTHER'S MAIDEN NAME

Kate Daussinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

NO

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. J P Smith

2850 W. Lanvale

18. E902.7 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Diabetes Stanley A. Douglas 1 year

CHIEF OR ASST. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Hypertensive Cardiovascular Disease 4 month
Fracture - R+ Hip 1 1/2 weeks

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Pneul Clinic

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Ellicott City, Md. 6300

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 7 - 1950 8 A. m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pt. Fell Out of Bed

22. I hereby certify that I attended the deceased from Aug. 14, 1950, to Aug. 19, 1950, that I last saw the
deceased alive on Aug. 19, 1950, and that death occurred at 530 P. m., from the causes and on the date stated above.

23A. SIGNATURE

James G. Douglas

M. D.

23B. ADDRESS

Bayne Ave + Cluhelms St.

23C. DATE SIGNED

19 Aug 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/22/50

24C. NAME OF CEMETERY OR CREMATORY

Western Cem.

24D. LOCATION (City, town, or county)

Baltimore Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

Aug 21 1950

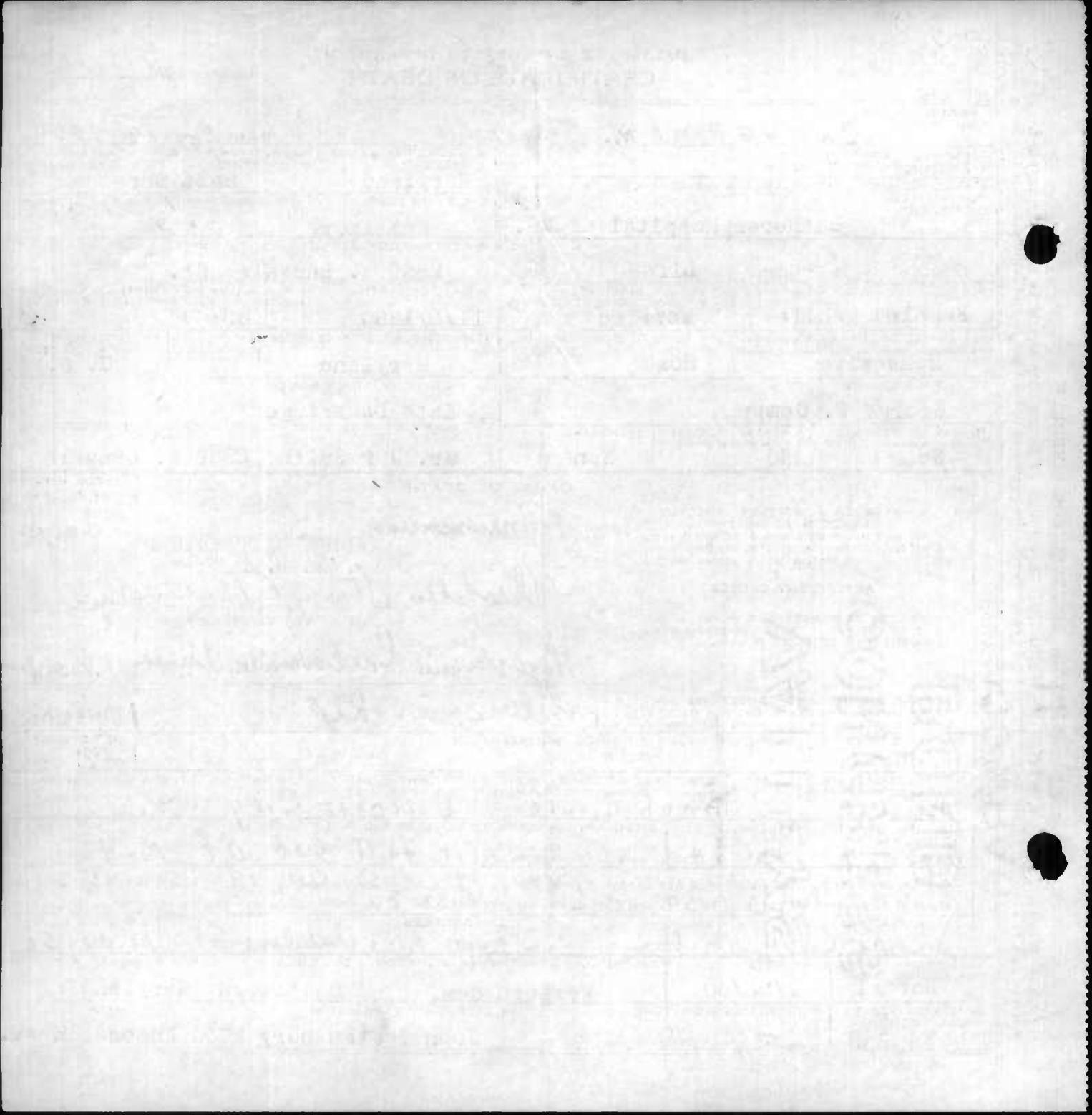
REGISTRAR'S SIGNATURE

Antington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John T Stansbury 2700 Edmondson Av.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Hattie May Coleman

2. DATE
OF
DEATH

Aug. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

119 N. Bantalou St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

119 N. Bantalou St.

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 28, 1892

9. AGE (in years
last birthday)

57

10. Under 1 Year
Months: Days

10 20

11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William F. Swann

14. MOTHER'S MAIDEN NAME

Laura Hentchel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.
None

17. INFORMANT

ADDRESS

Walter S. Coleman, 119 N. Bantalou

18. 175X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinomatosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

about 1 yr.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Chron. Arthritis - spine

many years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from July, 1949, to Aug 18, 1950, that I last saw the deceased alive on Aug 17, 1950, and that death occurred at 7:40 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Abram Goldman, M.D.

23B. ADDRESS

206 S. Gilman St. 23

23C. DATE SIGNED

Aug 19, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950

Huntington Williams, M.D.

Fred A. Cole, 1913 W. Balto. St.

See Document File 50-7190

9-5-50

If possible, please
state a more definite
anatomical location
of the malignant tumor.

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7191

BIRTH NO. 536

1. NAME OF DECEASED
(Type or Print)

Constance Anderson

2. DATE OF DEATH

Aug. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Fla.

B. COUNTY

V-08

B. FULL NAME OF (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Live Oak

D. STREET ADDRESS (If rural, give location)

503 Rogers St

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11-29-32

9. AGE (In years last birthday)

17

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Florida

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert Anderson

14. MOTHER'S MAIDEN NAME

Ellen Mc Knight

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

4564

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary fibrosis & emphysema

10 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Dis. Lupus Erythematosus

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/6, 1950, to 8/18, 1950, that I last saw the deceased alive on 8/18, 1950, and that death occurred at 5:00 PM, from the causes and on the date stated above.

23A. SIGNATURE

Thomas J. Walsh

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950

William Williams

Robert E. Williams

Continued from page 112

11-2-22
11-2-22

11-2-22

11-2-22

11-2-22

R-50 135 7192

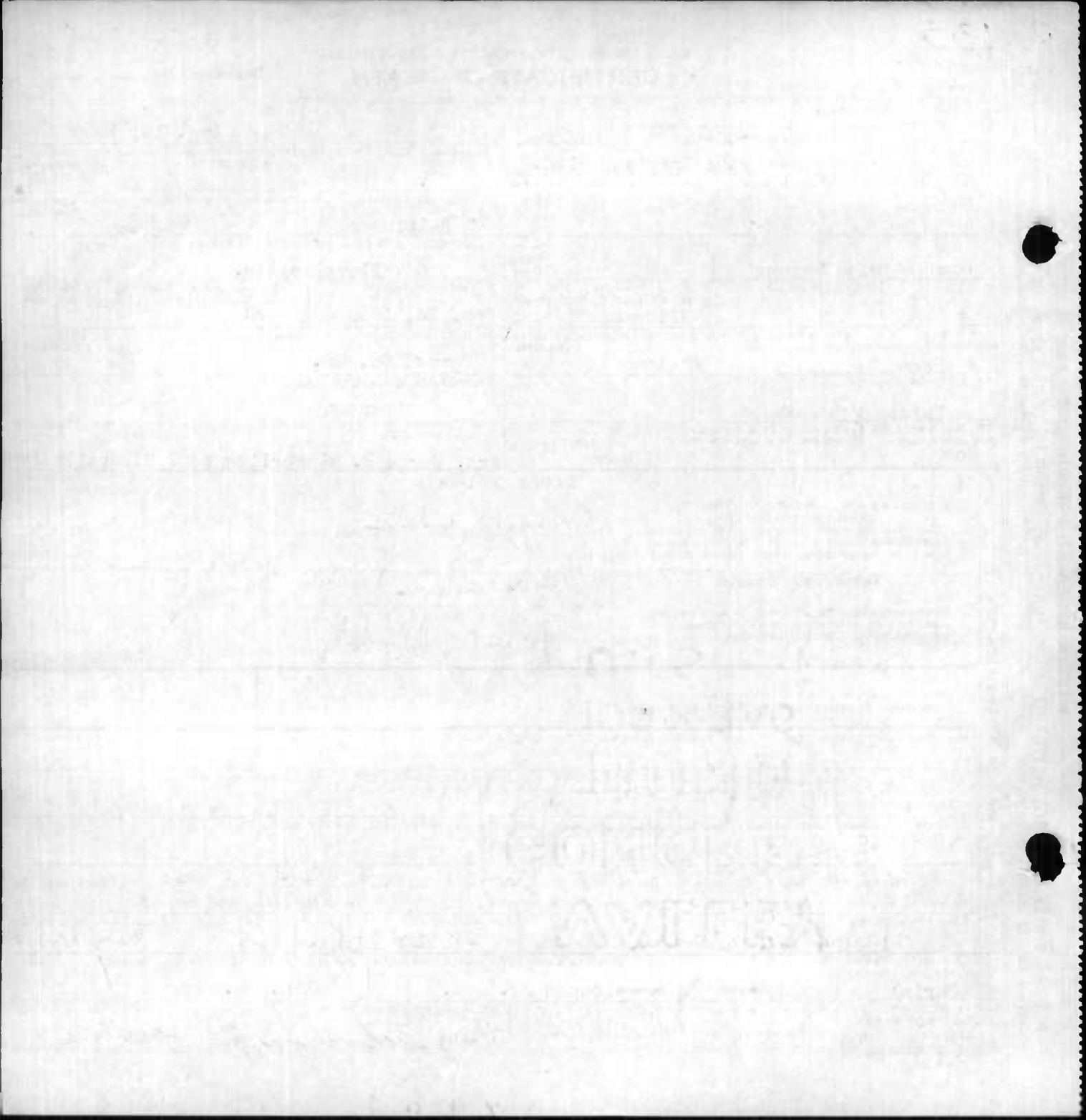
PLEASE WRITE IN FULLY, WITH UNFADING INK. Every item of information should be correctly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7192
Registered No.

| | | | | | | | | |
|--|------------------------------|---|---|--|--|---|--|--|
| BIRTH NO. | | | 1. NAME OF DECEASED (Type or Print) ELIZABETH K. REIBETANZ | | | 2. DATE OF DEATH Aug. 18, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 2803 Garrison Blvd. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-05 | | | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 60 | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | | | |
| c. Length of stay in Baltimore Yrs. 60 Mos. 60 Days 60 | | | D. STREET ADDRESS (If rural, give location) 3202 Ellerslie Ave. | | | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Feb. 16, 1858 | 9. AGE (In years last birthday) 92 | # Under 1 Year Months: 9 Days: 05 | # Under 24 Hours Hours: 10 Min: 00 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home | | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | | 11. BIRTHPLACE (State or foreign country) Howard Co. Md. | | |
| 13. FATHER'S NAME Herman Schmidt | | | 14. MOTHER'S MAIDEN NAME Unknown | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | | 16. SOCIAL SECURITY NO. None | | | 17. INFORMANT ADDRESS Mrs. Marie E. Winterling 3202 Ellerslie Ave | | |
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) myo. car. d. m. th | | | CAUSE OF DEATH (A) myo. car. d. m. th DUE TO (B) arterio-sclerotic changes in heart DUE TO (C) general senility | | | INTERVAL BETWEEN ONSET AND DEATH month | | |
| 18. II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from Aug 18, 1950 to Aug 18, 1950 , that I last saw the deceased alive on Aug 17, 1950 and that death occurred at m. from the causes and on the date stated above. | | | | | | | | |
| 23A. SIGNATURE Herbert M. Foster | | | 23B. ADDRESS 2424 St. Paul St | | | 23C. DATE SIGNED Aug 19-50 | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 8/21/50 | | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem. | | |
| 24D. LOCATION (City, town, or county) Balto. Md. | | | 24E. STATE Md. | | | 24F. COUNTY 9-05 | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1950 | | | REGISTRAR'S SIGNATURE Wm. J. Zickner | | | 25. FUNERAL DIRECTOR ADDRESS Wm. J. Zickner & Sons Inc North Pa | | |
| VS 150 | | | | | | 937 | | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7193

BIRTH NO. 50 - 16178

1. NAME OF DECEASED
(Type or Print)

NANCY L. Culbertson

2. DATE
OF
DEATH

8-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-09

c. Length of stay in Baltimore

18

Days

D. STREET ADDRESS (If rural, give location)

1328 Pentwood Rd.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

8-2-50

9. AGE (In years last birthday)

10 Under 1 Year Months: Days

18

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

I

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Warren Culbertson

14. MOTHER'S MAIDEN NAME

Evelyn Volk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Warren Culbertson 1328 Pentwood Rd.

18. 770.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Congestive Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

7 days

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Erythroblastosis fetalis

18 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 2, 1950, to Aug 20, 1950, that I last saw the deceased alive on Aug 20, 1950, and that death occurred at 12:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Alvin Bongelaar

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

Aug 20, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Western Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WILLY L.

WILLY L.

WILLY L.

WILLY L.



WILLY L.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 7194

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) **MR. ANTHONY F. PAGANO**

2. DATE OF DEATH **8/19/60**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **MARYLAND** B. COUNTY **BALTO.**

B. FULL NAME OF HOSPITAL OR INSTITUTION **St. Agnes Hosp.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTO., MD Haleshorpe

D. STREET ADDRESS (If rural, give location)
5606 CARVILLE Ave. 5300

c. Length of stay in Baltimore

5. SEX **M**

6. COLOR OR RACE **W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
M.

8. DATE OF BIRTH

12/21/1910

9. AGE (In years last birthday)
39 40

11 Under 1 Year
Months: Days:

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
AUTO MECH.

10B. KIND OF BUSINESS OR INDUSTRY
H.R. BORD CO.

11. BIRTHPLACE (State or foreign country)
Ind.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Pagano

14. MOTHER'S MAIDEN NAME

ELIZABETH Caton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Wm. Anne Pagano - 5606 Carville Ave.

18. **443X I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **SUBARACHNOID Hemorrhage**
DUE TO **Cerebro-vase-accident**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Hypertensive C. V. Disease**
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8/15, 1960** to **8/19, 1960** that I last saw the deceased alive on **4/19, 1960** and that death occurred at **4:30 AM** from the causes and on the date stated above.

23A. SIGNATURE

John C. Heales

23B. ADDRESS

St. Agnes Hosp 8/19/60

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

8-23-60

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county) (State)

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

George A. Taylor, Baltimore

AUG 21 1960

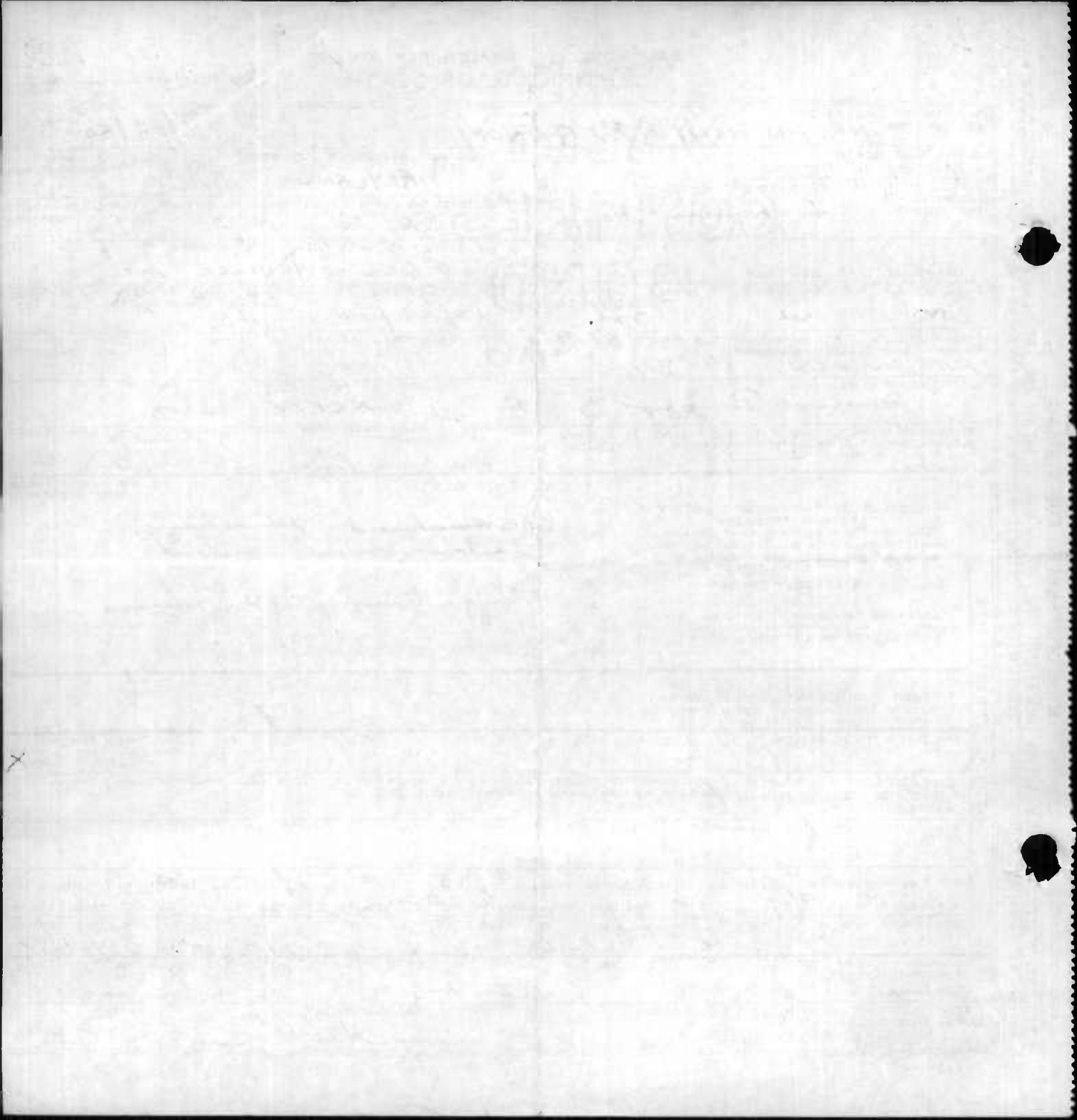
VS 150

55060

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 7195**

 BIRTH NO. **50 7195**

| | | | | | |
|--|------------------------------|---|---|-----------------------|---|
| 1. NAME OF DECEASED (Type or Print) Edgar D. Walker | | | 2. DATE OF DEATH Aug. 17, 50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 3011 Christopher Av | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 27-05 | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 60 | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore Yrs. 60 Mos. 60 Days 60 | | | D. STREET ADDRESS (If rural, give location) 3011 Christopher Ave. | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Junell, 97 | | 9. AGE (In years last birthday) 53 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucking | | | 10B. KIND OF BUSINESS OR INDUSTRY E.D. Walker Son | | 11. BIRTHPLACE (State or foreign country) Harford Co. |
| 13. FATHER'S NAME Henry G. | | | 14. MOTHER'S MAIDEN NAME Clara R. Hunt | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |

| | | | | | |
|---|--|---|----------------------------------|--|--|
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Hypertensive arteriosclerosis DUE TO cardio vascular disease. 5 years (B) DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from June 1942 , to Aug. 17, 1950 , that I last saw the deceased alive on Aug. 16, 1950 and that death occurred at 4:00 p.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Donald A. Graft | | 23B. ADDRESS 8100 Harford Rd. | | 23C. DATE SIGNED 8/19/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 28, 50 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cem. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1950 | | REGISTRAR'S SIGNATURE Walter J. Williams, M.D. | | 25. FUNERAL DIRECTOR 6067 Harford Rd. Heemann Funeral Home. | |

H.A. Grott
8100 Harford

3010 Altman

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7196
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY E. STEADMAN

2. DATE
OF
DEATH

8-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTIMORE

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

2706 GIBBONS AVE

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2706 GIBBONS AVE.

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

Widowed

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Cain

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. Wm E. Steadman 2706 Gibbons Ave.

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary vascular thrombosis

11 mm

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

unilateral

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 Aug, 1949, to Aug 20, 1950, that I last saw the deceased alive on 20 Aug, 1950, and that death occurred at 11:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Howard Johnson

23B. ADDRESS

1513 N. Mt. Vernon Ave

23C. DATE SIGNED

21 Aug 1950

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8-23-50

Cathedral Cemetery Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950

Washington Williams, M.D.

Elmer W. Conklin 924 Eager St.

VS 150

131a

MARGIN RESERVED FOR BINDING

Don. H. Goodenow

1513 N. Millon

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7197

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth C. Hart

2. DATE
OF
DEATH

8-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1033 Homewood Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 10-01

D. STREET ADDRESS (If rural, give location)

1033 Homewood Ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

39

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10-4-1888

9. AGE (In years last birthday)

61

10. Under 1 Year Months Days

18 14

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House work at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hugh Clinton

14. MOTHER'S MAIDEN NAME

Delia Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Thomas F. Hart 1033 Homewood Ave

ADDRESS

one

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atherosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from May, 1945 to 8/18/1950, that I last saw the deceased alive on 8/11, 1950 and that death occurred at 2pm, from the causes and on the date stated above.

23A. SIGNATURE

John R. Carter

23B. ADDRESS

Medical Arts Bldg

23C. DATE SIGNED

8/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-22-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Elmer W. Conklin 924 E. Eager

ADDRESS

AUG 21 1950

Dr. John R. Davis
Medical Art. Bldg.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7198
Registered No.

1. NAME OF DECEASED
(Type or Print)

NORMA DE LUVA

2. DATE
OF
DEATH

Aug 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **H.L.H 3E.**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admision)
A. STATE **TEXAS** B. COUNTY **V-40**

B. FULL NAME OF HOSPITAL OR INSTITUTION **JOHNS HOPKINS HOSPITAL**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BROWNSVILLE

c. Length of stay in Baltimore

Yrs.
Mos.
Days

O. STREET ADDRESS (If rural, give location)
425 SHERRY AVE.

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
-

B. DATE OF BIRTH

8-23-48

9. AGE (in years last birthday)

1 YR

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Luig DeLuva

14. MOTHER'S MAIDEN NAME

Mary Trivino

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. **754.4**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Congenital Heart & Brain Abscess

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **8-17** 19**50**, to **8-20** 19**50**, that I last saw the deceased alive on **8-20** 19**50**, and that death occurred at **7:05** P.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Gustafson M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950

William M. Williams, M.D.

1214 St Paul St

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

120
50 7199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7199
Registered No. _____

| | | | | | |
|--|------------------------------|---|-----------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Mary Tivvis</i> | | 2. DATE OF DEATH <i>8-19-50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1000 Caton Ave.</i> | | B. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Jackson's Memorial Hospital</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> | | | |
| C. Length of stay in Baltimore <i>52</i> | | D. STREET ADDRESS (If rural, give location) <i>1919 Argonuth St</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i> | 8. DATE OF BIRTH <i>7-9-98</i> | 9. AGE (In years last birthday) <i>52</i> | 10. Under 1 Year Months: <i>1</i> Days: <i>10</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Frederick Rubbel</i> | | 14. MOTHER'S MAIDEN NAME <i>Louise Schendelle</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mr. John Tivvis</i> | |
| 17. ADDRESS | | | | | |
| 18. <i>191X</i> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>SARCOMA RT. FEMUR -</i> | | | |
| DUE TO | | (B) <i>BILATERAL PLEURAL EFFUSION & PULMONARY EDEMA -</i> | | | |
| DUE TO | | (C) <i>ANEMIA</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>8/21/50</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <i>8/19</i> , 19 <i>50</i> , and that death occurred at <i>3:25 PM</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>J. H. Allen, M.D.</i> | | 23B. ADDRESS <i>1214 S. Bond St</i> | | 23C. DATE SIGNED <i>8/19/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/21/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore Md</i> | | 24E. LOCAL REGISTRAR <i>Wm. H. Williams, Jr.</i> | | 24F. REGISTRAR'S SIGNATURE <i>Wm. H. Williams, Jr.</i> | |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1950</i> | | 24H. FUNERAL DIRECTOR <i>Wm. H. Williams, Jr.</i> | | 24I. ADDRESS <i>1214 S. Bond St</i> | |

RECEIVED

DATE

RECEIVED

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7200

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE WILSON GUINN

2. DATE
OF
DEATH

August 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

a. a.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

S. Balt. General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Linthicum Heights

D. STREET ADDRESS (If rural, give location)

510 W. Shipley Rd

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

5/15/1923

9. AGE (In years last birthday)

27

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stationary Fireman

10B. KIND OF BUSINESS OR INDUSTRY

Construction Co.

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edward Guinn

14. MOTHER'S MAIDEN NAME

Anna Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W. W. # 2

16. SOCIAL SECURITY NO.

17. INFORMANT

Old Mill Rd
Brax. Guinn Elcton Hgts. a. a. Co.

18. E 873.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ...

Fracture of skull

ANTECEDENT CAUSES

(B) ...

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) ...

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Route 301 4 miles south of Glen Burnie

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 19, 1950 P. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Driver of car that hit tree

22. I certify that I took charge of the remains described above, held an inspection and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Duncanson

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 20, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

a. a. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm Cook Inc 1217 St. Paul St.

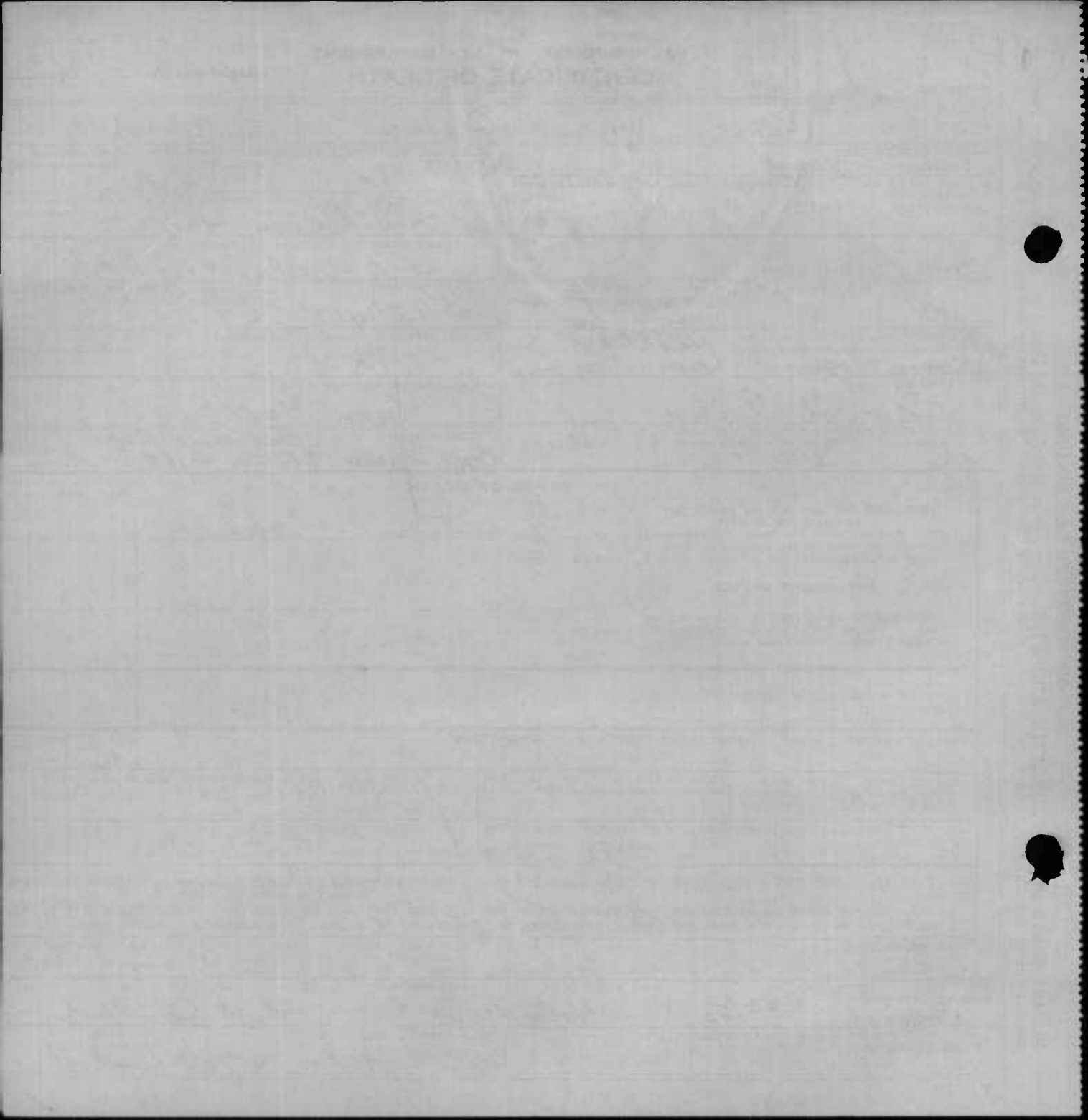
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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 7201**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BENJAMIN W. GUINNY Jr.

2. DATE
OF
DEATH

August 19, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

MD

A. A. Co.

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

S. Balt. General Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Elvaton Heights

d. STREET ADDRESS (If rural, give location)

Old Mill Rd.

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

6/8/1934

9. AGE (In years last birthday)

16

If Under 1 Year Months: Days

2 11

If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Benj. W. Guinn Sr.

14. MOTHER'S MAIDEN NAME

Isabelle Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Benj. W. Guinn Sr.

Elvaton Heights, A. A. Co. Md.

18. **E823.4**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Fracture of Skull

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Street

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Route 301, 4 miles south of Glen Burnie

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 19, 1950

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

Passenger of car which hit tree.

22. I certify that I took charge of the remains described above, held an **Inspection** and **Inquiry** thereon and from the evidence obtained by said ~~Autopsy~~ **Inspection or Inquiry**, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

Stanley H. Dineen

M.D.

23b. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23c. DATE SIGNED

August 20, 1950

24a. BURIAL CREMATION REMOVAL (Specify)

Burial

24b. DATE

8/23/50

24c. NAME OF CEMETERY OR CREMATORY

Holy Cross

24d. LOCATION (City, town, or county)

A. A. Co. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William M. Williams

25. FUNERAL DIRECTOR

ADDRESS

Wm Cook Inc. 1217 St. Paul St.

VS 151

N-803.2

1700

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7202

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND

BOB LITZ

2. DATE
OF
DEATH

August 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6648 Eastern Ave.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

2/26/1933

9. AGE (In years
last birthday)

17

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Nelson

10B. KIND OF BUSINESS OR
INDUSTRY

Nelson Box Co.

11. BIRTHPLACE (State or foreign country)

Balto. Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Brinson Bob Litz

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James E. Foster Jr. 2110 Mayer St.

18. E816.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Basilar fracture of skull

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Intracranial hemorrhage

DUE TO

(C) Compound fracture of left leg

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

XXXX NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

Baltimore County

Eastern Ave. & Moffett Ave.

5300

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 19, 1950 1:50 A.M.

21E. INJURY OCCURRED
WHILE AT NOT WHILE
WORK AT WORK

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

Truck struck by auto, passenger thrown

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Dineen

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 19, 1950

24A. BURIAL CREMA-
TION REMOVAL (Specify)

Burial

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Eastern Ave. Extended

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

Wm Cook Inc. 127 St. Paul St.

ADDRESS

170C

VS 151

N-804.2

69032

Item 18 C - incomplete

63138-30

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7203

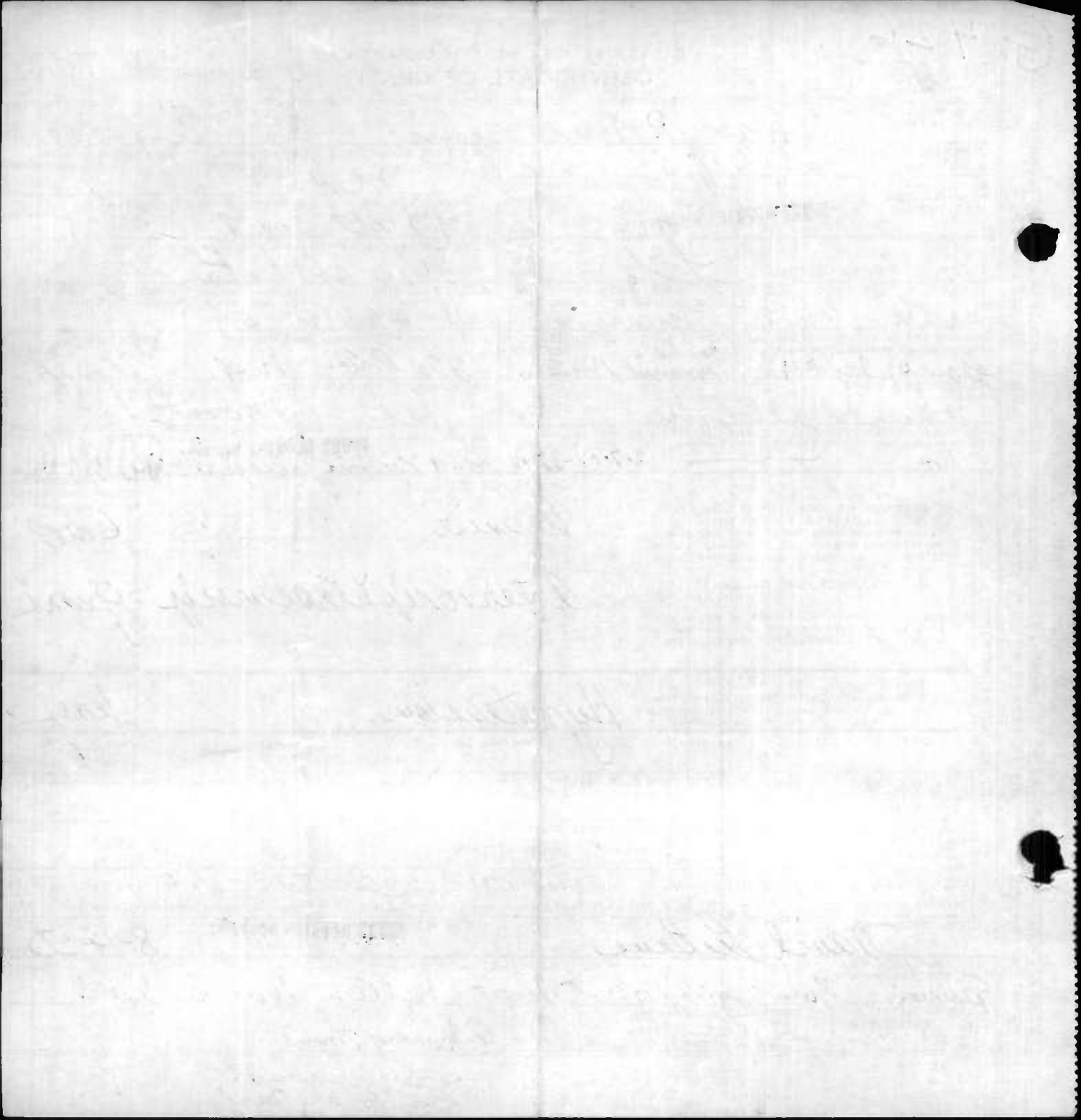
50 7203

BIRTH NO.

| | | | |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Harry P. Gallagher</i> | | 2. DATE OF DEATH <i>Aug 19, 1950</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Dist 6 - med.</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHN HOPKINS HOSPITAL</i> | | C. CITY OR TOWN (If outside corporate limits, write R.U.M. and give township) <i>Baltimore 25-04</i> | |
| c. Length of stay in Baltimore <i>Life -</i> | | D. STREET ADDRESS (If rural, give location) <i>3610 St Victor St.</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i> | 8. DATE OF BIRTH <i>11-29-1890</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boiler maker -</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Repaired Boilers</i> | 9. AGE (in years last birthday) <i>59</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Balto., md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Gallagher</i> | | 14. MOTHER'S MAIDEN NAME <i>Helen Mooney</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>217-07-3741</i> | |
| 17. INFORMANT <i>JOHN HOPKINS HOSPITAL</i> | | ADDRESS <i>Mrs. A. Victoria Gallagher (wife) alone</i> | |
| 18. 446X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Uremia</i> | | CAUSE OF DEATH (A) <i>Uremia</i> DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerosis</i> | | (B) <i>Arteriosclerosis</i> DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertension</i> | | (C) <i>Hypertension</i> DUE TO | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>8-11-</i> , 19 <i>50</i> to <i>8-19-</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>8-17-</i> , 19 <i>50</i> , and that death occurred at <i>11:55 a.m.</i> , from the causes and on the date stated above. | | | |
| 23A. SIGNATURE <i>David Leebens</i> | | 23B. ADDRESS <i>JOHN HOPKINS HOSPITAL</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial -</i> | | 24B. DATE <i>Tues. Aug. 22, 1950</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>St. Vincent de Paul Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i> | |
| 25. FUNERAL DIRECTOR <i>Huntington Williams, Inc.</i> | | ADDRESS <i>1400 S. Charles St. - Balto 30, Md.</i> | |

VS 150

503 84 1400 S. Charles St. - Balto 30, Md. 131a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Leopold Jacobson

2. DATE
OF
DEATH

Aug 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

13-04

D. STREET ADDRESS (If rural, give location)

7413 Holmes Ave

C. Length of stay in Baltimore

70

Yrs.
Mo.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

divorced

8. DATE OF BIRTH

9. AGE (In years last birthday)

88

10 Under 1 Year Months Days
11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ruth

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Tamchom

14. MOTHER'S MAIDEN NAME

Etta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

William Jacobson 2418 Liberty Hgts

18. *586X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Perforated Gall-Bladder

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic Cardio-Vascular Disease

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
Aug 8-1950
Aug 20-1950

19A. DATE OF OPERATION

Aug 12, 1950

19B. MAJOR FINDINGS OF OPERATION

perforated gall-bladder

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug 8, 1950* to *Aug 20, 1950*, that I last saw the deceased alive on *Aug 20, 1950*, and that death occurred at *11:45* a.m., from the causes and on the date stated above.

23A. SIGNATURE

Emas B. Beingard

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-21-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Herring Run

24D. LOCATION (City, town, or county)

Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis Inc

ADDRESS

2100 Eutaw Pl

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7205
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

506 J. KAPLAN

2. DATE
OF
DEATH

8-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

Md

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

20900 Freemont Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

20900 Freemont Ave

C. Length of stay in Baltimore

37

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (In years last birthday)

57

10 Under 1 Year

11 Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

Liquor Store

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph

14. MOTHER'S MAIDEN NAME

Fagca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mamie Kaplan - Daur

ADDRESS

18.

153X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of sigmoid c

DUE TO

metastases

INTERVAL BETWEEN ONSET AND DEATH

unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

May 18, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of sigmoid c metastases

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 18, 1950*, to *8/20*, 19*50*, that I last saw the deceased alive on *8/10*, 19*50*, and that death occurred at *9:15* p. m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Harry Ashman

23B. ADDRESS

1921 W North Ave

23C. DATE SIGNED

8/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/22/50

24C. NAME OF CEMETERY OR CREMATORY

Herring Run

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis Inc - 2100 Eutaw Pl

ADDRESS

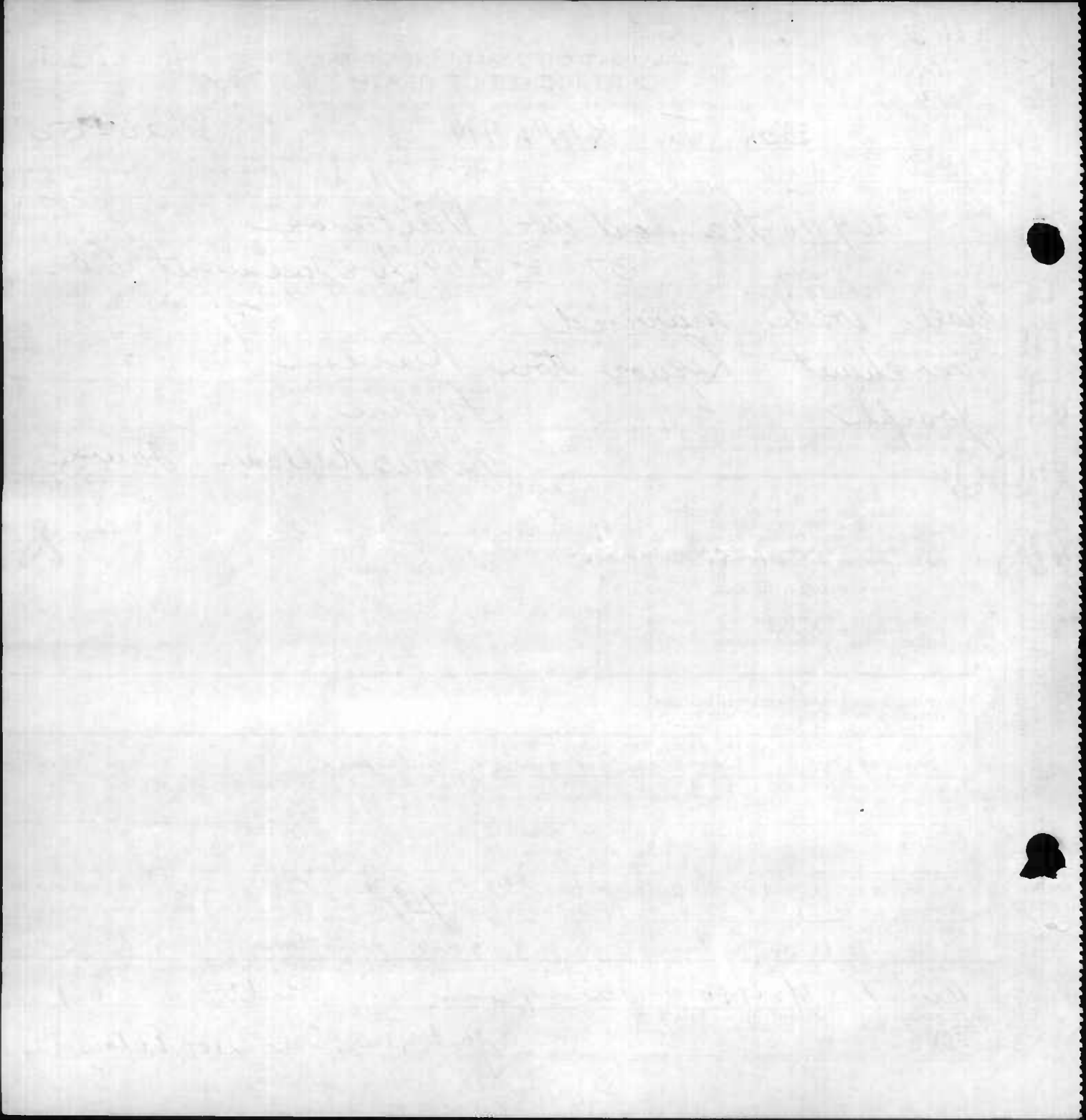
VS 150

29069

46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

SAM GOLDIN

2. DATE
OF
DEATH

8-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1949 to August 21, 1950, that I last saw the deceased alive on Aug 21, 1950, and that death occurred at 6:47 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

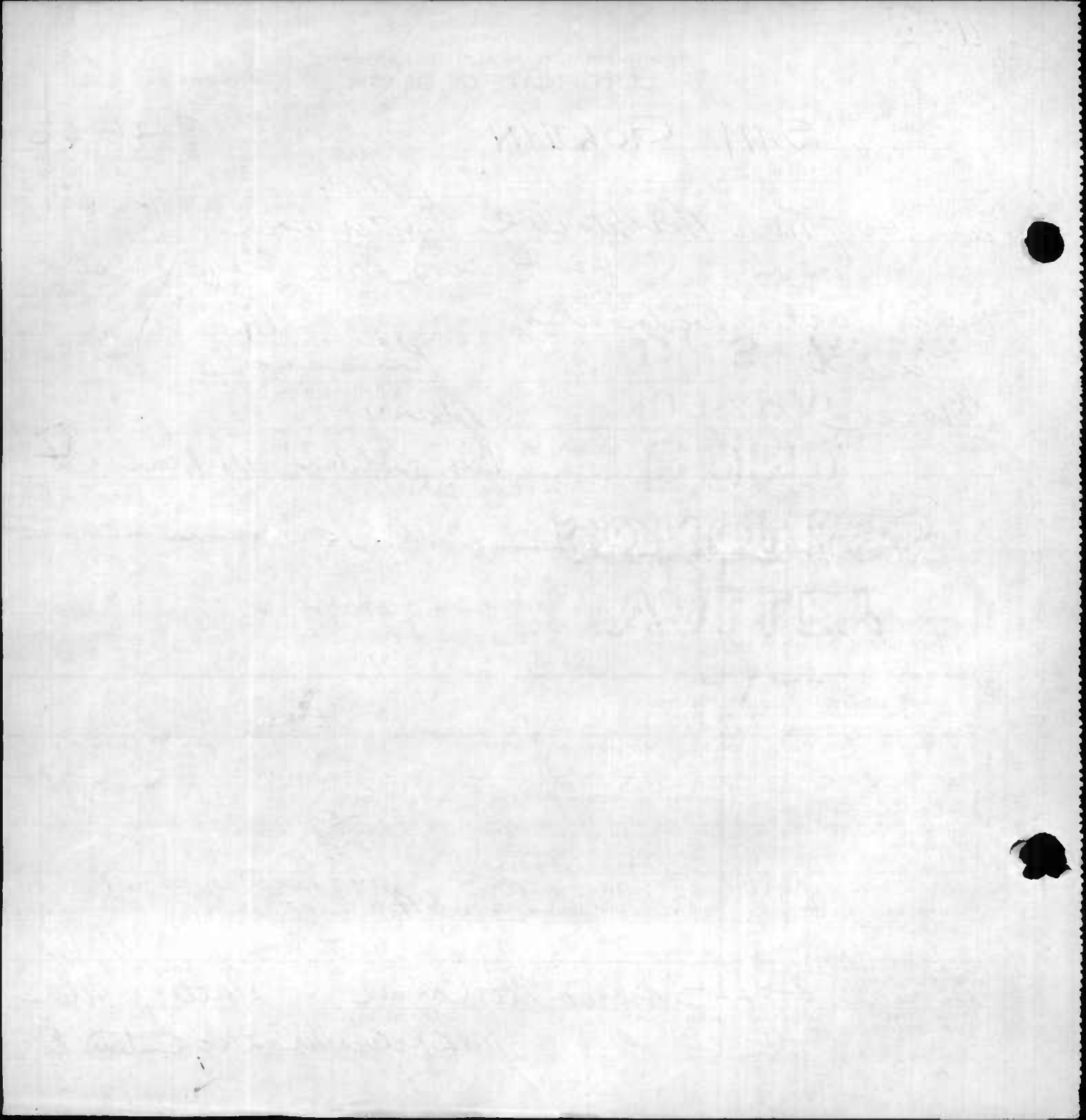
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7207

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lester N Hollinger

2. DATE
OF
DEATH

AUG 20 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

138 S. West St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

divorced

8. DATE OF BIRTH

6-9-09

9. AGE (in years
last birthday)

41

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles E. Hollinger

14. MOTHER'S MAIDEN NAME

Lucinda Lauchman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Carcinoma of the

DUE TO

Primary Site Undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

13 mo

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-17-1950 to 8-20-1950 that I last saw the
deceased alive on 8-20-1950 and that death occurred at 5:20 P.M., from the causes and on the date stated above.

23A. SIGNATURE

David L. Lusk

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-20-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950
VS 150

Lester N. Hollinger, M.D.

Dunfee Funeral Home, 363 Falls
469 Road

From autopsy findings

Could you please state a
more definite anatomical
location of the malignant
tumor

State here only,
not to be copied for
transcript

"Undifferentiated carcinoma (frozen section) involving
retroperitoneal lymph nodes, pancreas, both kidneys
and bronchial lymph node"

• See Document File for full anatomical findings

9.7.50

EV

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)*Joseph W Fink*2. DATE
OF
DEATH*8/20/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

MERCY HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

8-10

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

MERCY HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

C. Length of stay in Baltimore

*Most of**Life*Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

*2913 Lafayette St.**(2413)*

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb 18 1883

9. AGE (In years last birthday)

67

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unk

10B. KIND OF BUSINESS OR INDUSTRY

Barber

11. BIRTHPLACE (State or foreign country)

Penna

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Joseph Fink

14. MOTHER'S MAIDEN NAME

Mary Post

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unk

16. SOCIAL SECURITY NO.

Unk

17. INFORMANT

Robert Humphrey

ADDRESS

*Same*18. *153 X I*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Colloid Carcinoma of large bowel & metastases*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

11/22/49

19B. MAJOR FINDINGS OF OPERATION

Carcinomatosis of abdomen

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/19*, 19*50*, to *8/20*, 19*50*, that I last saw the deceased alive on *8/20*, 19*50*, and that death occurred at *2:35 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Charles P. Ireland

M. D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

8/20/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 23rd 1950

24C. NAME OF CEMETERY OR CREMATORY

Mowlands

24D. LOCATION (City, town, or county) (State)

Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

William M. Williams, M.D.

25. FUNERAL DIRECTOR

Leslie Leach 1701 1/2 Patterson Park Ave

ADDRESS

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7209
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

BERNICE

SMITH

2. DATE
OF
DEATH

AUG. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE **BALTO.** B. COUNTY **city and Md.**

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1224 RANKIN PL.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE CITY

c. Length of stay in Baltimore

20 yrs.

D. STREET ADDRESS (If rural, give location)

1224 RANKIN PL.

5. SEX

F

6. COLOR OR RACE

cc.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

5-12-14

9. AGE (In years last birthday)

36

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm S. Boardley

14. MOTHER'S MAIDEN NAME

LUDIE R WHEELER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

None

17. INFORMANT

LUDIE R. Wheeler 1224 RANKIN PL.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

401.1
Mitral Stenosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Acute Rheumatic Fever

(C)

INTERVAL BETWEEN ONSET AND DEATH

15 yrs.?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

NO

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **3-15-49**, 19**50**, to **8-18-50**, 19**50**, that I last saw the deceased alive on **8-18-** 19**50**, and that death occurred at **11:45 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

Shawne L. Brown, M.D.

23B. ADDRESS

238 N. Cary St

23C. DATE SIGNED

8-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/22/50

24C. NAME OF CEMETERY OR CREMATORY

Brown's Chapel

24D. LOCATION (City, town, or county)

Dayton Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, Md.

25. FUNERAL DIRECTOR

J.C. Higginbotham Ellwood City Md.

ADDRESS

AMERICAN NATIONAL TRUST AND SAVINGS BANK
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S M maiden NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

2 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/5, 1950 to 8/18, 1950, that I last saw the
deceased alive on 8/18, 1950 and that death occurred at 7 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

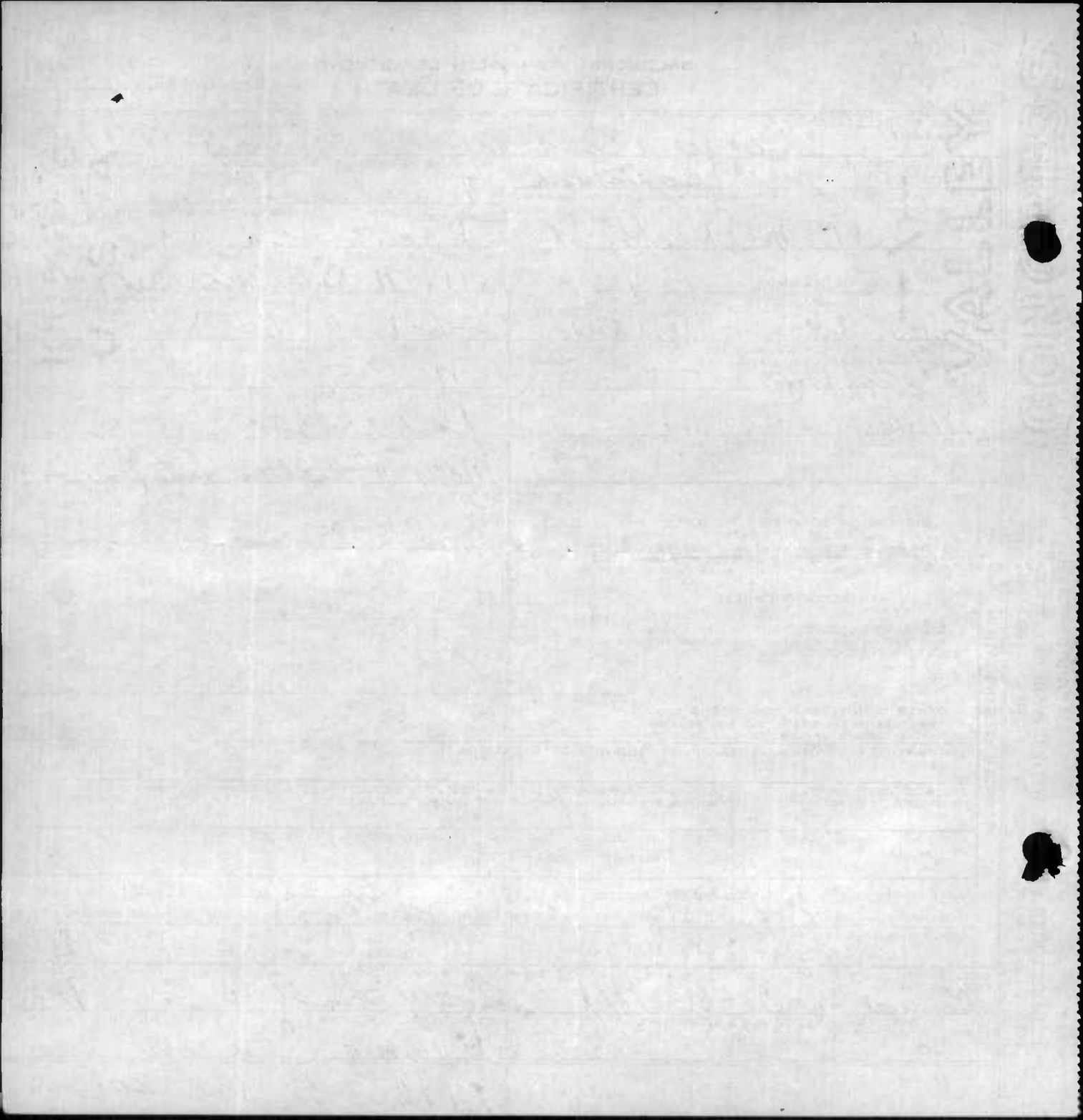
(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MINNIE LEE BOUIS

2. DATE
OF
DEATH

Aug. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3604 Mohawk Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Fla.

B. COUNTY

V-08

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Plant City

D. STREET ADDRESS (If rural, give location)

555 Shannon Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Sept. 10, 1869

9. AGE (In years
last birthday)

80

If Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jacob Snyder

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

-

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr. Sydney S. Bouis 555 Shannon Ave.,
Plant City, Fla.

18.

162X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Broncho pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Primary Bronchogenic Carcinoma

1 year

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease 6 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 29, 1937, to August 19, 1950, that I last saw the deceased alive on Aug 19, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Edith

M. D.

23B. ADDRESS

3403 Garrison Blvd

23C. DATE SIGNED

Aug 21, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Theresa J. Williams, M.D.

25. FUNERAL DIRECTOR

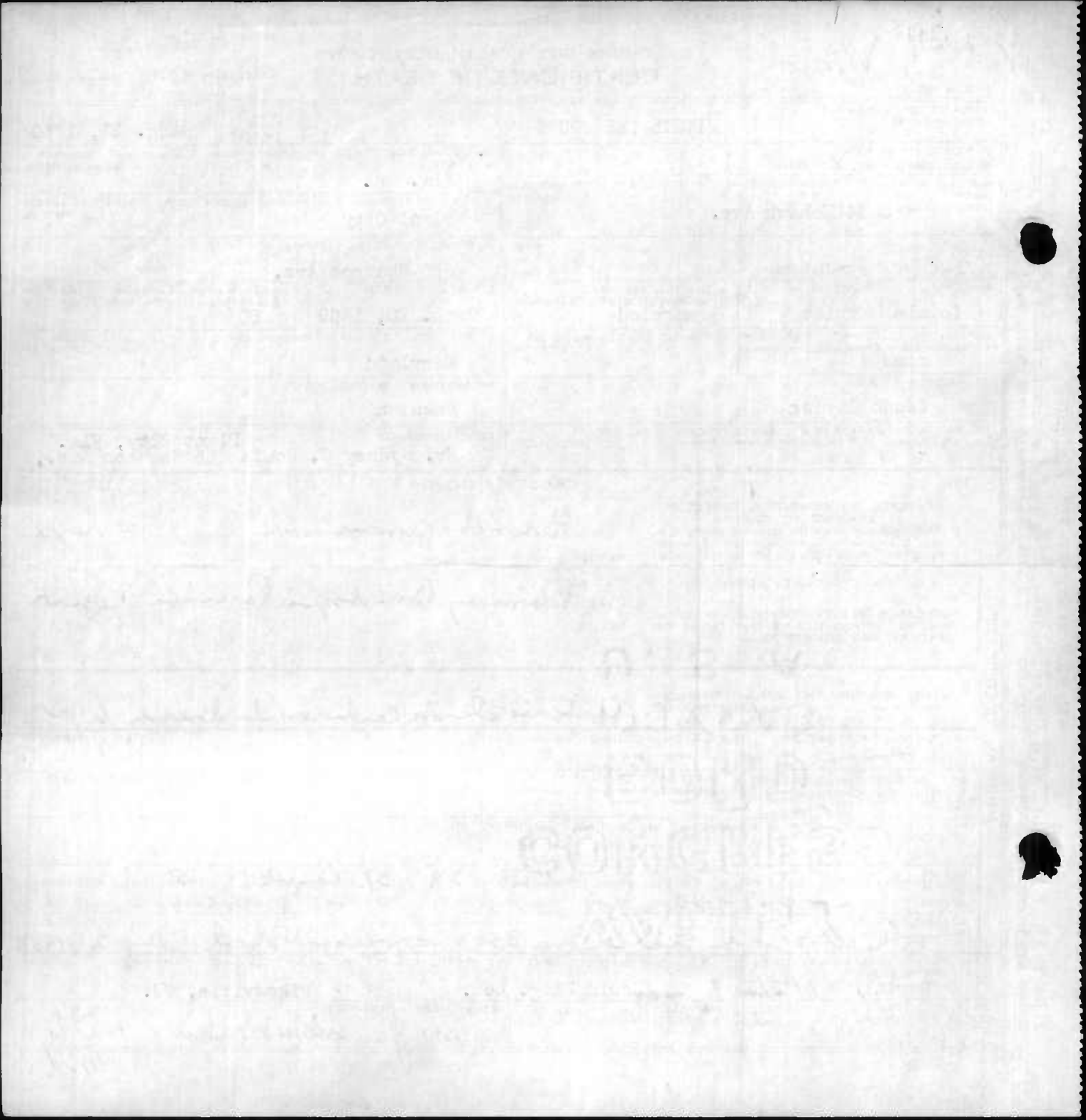
Thm. J. Pickner & Sons

ADDRESS

Baltimore, Md.

AUG 21 1950
VS 150

47c



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1008 N. Fulton Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN Md. (If outside corporate limits, write FULL and give township)

1008 N. Fulton Ave.

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

If Under 1 Year

If Under 24 Hours

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 4/20.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CERTIFICATION APPROVED BY

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at 8 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

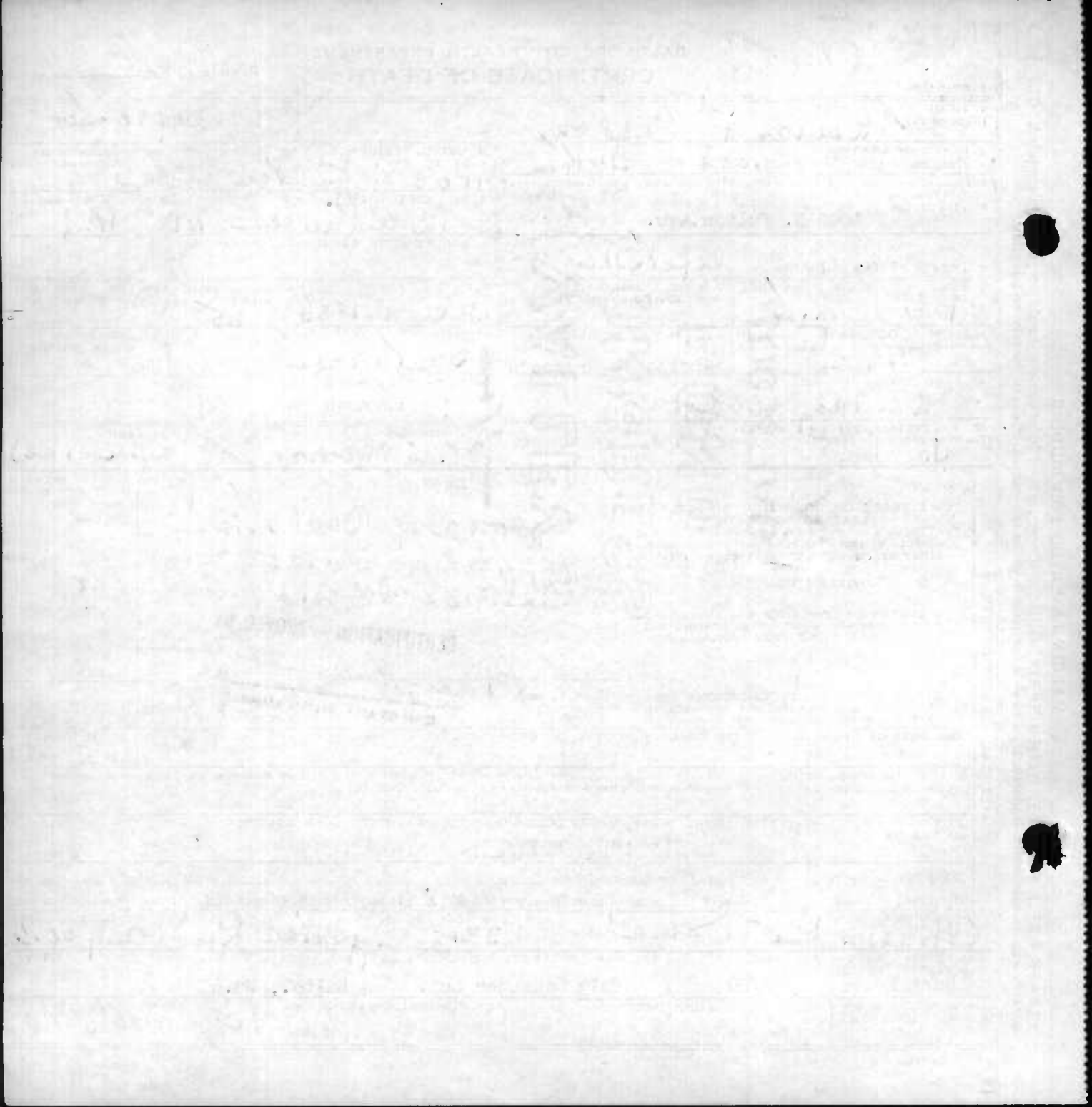
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

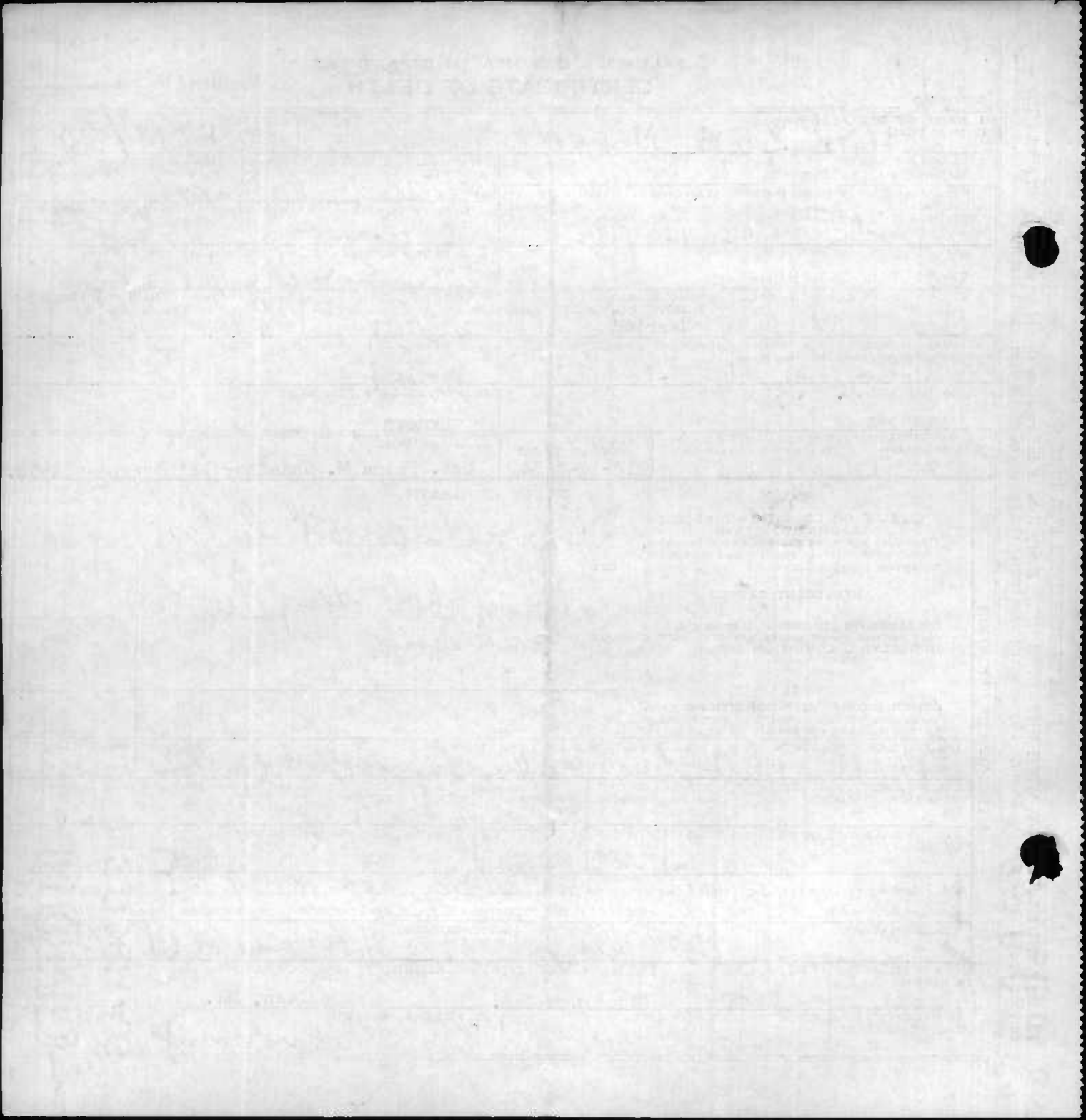
| | | | | | |
|---|---------------------------|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Antony Lorenz Meyer</i> | | | 2. DATE OF DEATH <i>8/19/50</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Joseph's Hospital</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>9-02</i> | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) <i>2113 Kentucky Av.</i> | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>1/26/1871</i> | | 9. AGE (In years last birthday) <i>79</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>salesman (rtd)</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <i>unknown</i> | | | 14. MOTHER'S MAIDEN NAME <i>unknown</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-no</i> | | 16. SOCIAL SECURITY NO. <i>213-14-2854</i> | 17. INFORMANT ADDRESS <i>Mrs. Palma M. Shaeffer 111 Greenway Apts.</i> | | |

MEDICAL CERTIFICATION

| | | |
|---|---|----------------------------------|
| 18. <i>570.5</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH (A) <i>Congestive heart failure</i> DUE TO (B) <i>Bowel obstruction due to adhesions</i> DUE TO (C) | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|--|--|
| 19A. DATE OF OPERATION <i>8/7/50</i> | 19B. MAJOR FINDINGS OF OPERATION <i>B. Obstruction due to post-operative adhesions</i> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <i>8/6</i> , 19 <i>60</i> , to <i>8/19</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>8/19</i> , 19 <i>50</i> , and that death occurred at <i>7:22 p.m.</i> , from the causes and on the date stated above. | | |
| 23A. SIGNATURE <i>B. B. B. B.</i> | 23B. ADDRESS <i>1400 N. Caroline St.</i> | 23C. DATE SIGNED <i>8/19/50</i> |

| | | | |
|---|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>8/22/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem.</i> | 24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>Aug 21 1950</i> | REGISTRAR'S SIGNATURE <i>Thurston Williams</i> | 25. FUNERAL DIRECTOR <i>Edm J. Tucker & Sons - Balto</i> | ADDRESS <i>Md.</i> |

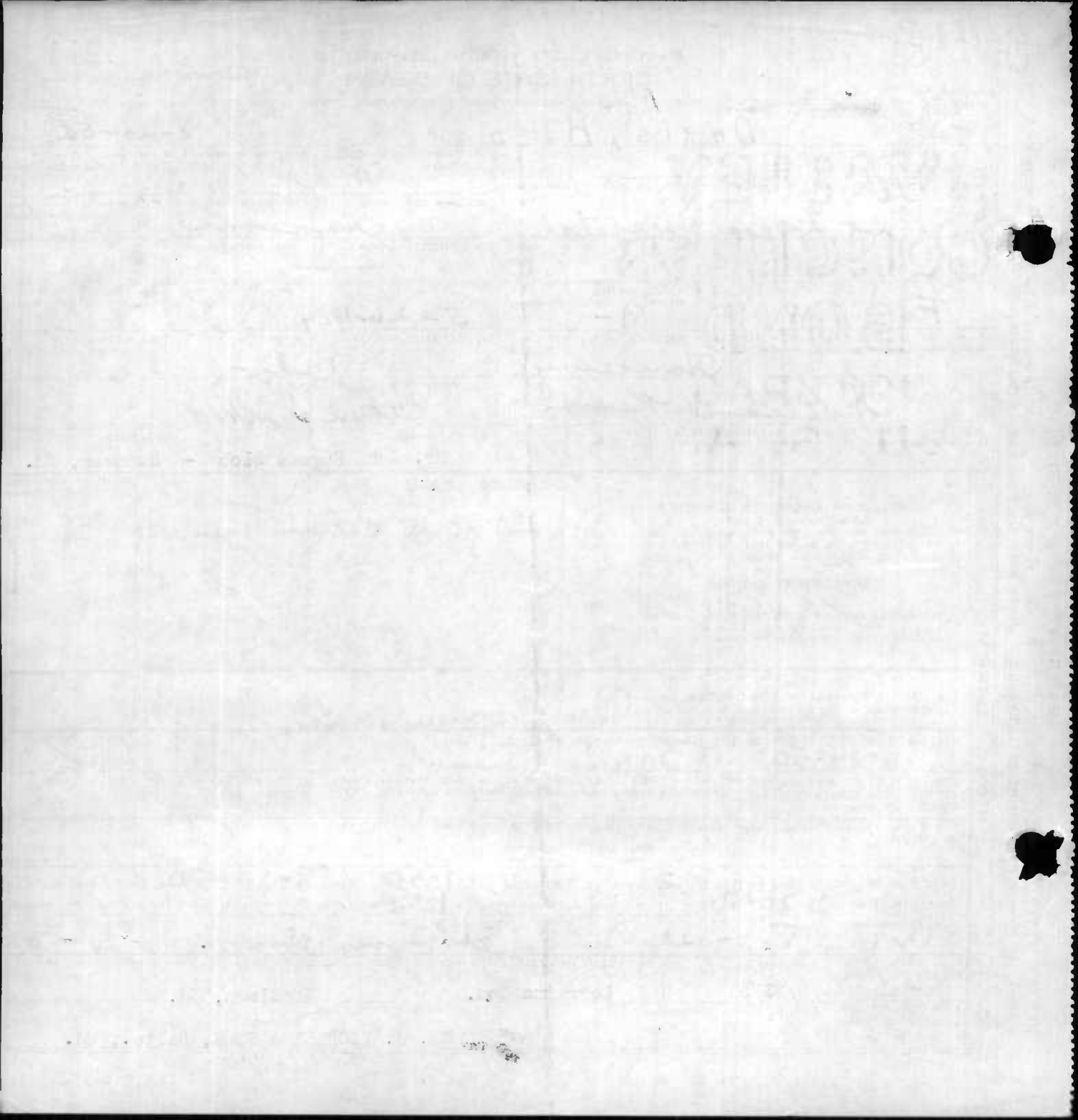


BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7214

| | | | | | |
|--|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Mae Doris Blob</i> | | 2. DATE OF DEATH <i>8-20-50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Howard</i> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Hanover</i> D. STREET ADDRESS (If rural, give location) <i>6300</i> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Agnes' Hospital</i> | | 5. SEX <i>F.</i> 6. COLOR OR RACE <i>W</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M -</i> | | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | 8. DATE OF BIRTH <i>5-26-1924</i> | | 9. AGE (In years last birthday) <i>26</i> If Under 1 Year Months Days If Under 24 Hours Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md -</i> | |
| 13. FATHER'S NAME <i>William Kent</i> | | 14. MOTHER'S MAIDEN NAME <i>Ethel Fisher</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Mr. John Eugene Blob - Hanover, Md.</i> | |
| 18. <i>193X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Malignant Brain Tumor</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Brucellosis</i> | | | |
| 19A. DATE OF OPERATION <i>8-19-50</i> | | 19B. MAJOR FINDINGS OF OPERATION <i>Brain tumor</i> | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>8-17-50</i> to <i>8-20-50</i> , that I last saw the deceased alive on <i>8-20-50</i> and that death occurred at <i>12:30 P.M.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Arthur T. Hall Jr.</i> M. D. | | 23B. ADDRESS <i>St. Agnes Hosp.</i> | | 23C. DATE SIGNED <i>8-20-50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/23/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i> | | 25. FUNERAL DIRECTOR ADDRESS <i>WM. J. TICKNER & SONS, Balto., Md.</i> | | | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1950</i> | | REGISTRAR'S SIGNATURE <i>Handwritten Signature</i> | | VS 150 | |

54 B



| BIRTH NO. | | | | Baltimore City Health Department | | | | Registered No. | | | |
|---|----------------------------------|---|--|--|--|---|----------------------------------|---|-----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) John Thomas Faulkner | | | | 2. DATE OF DEATH 8-19-50 | | | | | | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | | | | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | | 26-19 | | | |
| C. Length of stay in Baltimore Life | | | | D. STREET ADDRESS (If rural, give location) 344 Bouldin Street (Bowling St) - S. | | | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH October 16, 1869 | | 9. AGE (in years last birthday) 80 | 10. Under 1 Year Months: Days | | 11. Under 24 Hours Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY Crown, Cork and Seal Co., Maryland | | 11. BIRTHPLACE (State or foreign country) Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Henry Faulkner | | | | 14. MOTHER'S MAIDEN NAME Mary Wilson | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Records* Balto. City Hospitals Eastern Ave | | | | ADDRESS 4940 | | | |
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Terminal Heart Failure with arteriosclerotic Cardio-Vascular Disease | | | | CAUSE OF DEATH (A) Terminal Heart Failure with arteriosclerotic Cardio-Vascular Disease DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Gangrene of right great toe | | | | (B) Gangrene of right great toe DUE TO | | | | 23 Days | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Pneumoniatis | | | | | | | | | | | |
| 19A. DATE OF OPERATION 8-11-50 | | 19B. MAJOR FINDINGS OF OPERATION Gangrene right great toe | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I hereby certify that I attended the deceased from 8-1 , 19 50 to 8-19 , 19 50 , that I last saw the deceased alive on 8-19 , 19 50 and that death occurred at 11:45 p.m. from the causes and on the date stated above. | | | | | | | | | | | |
| 23A. SIGNATURE J. Rozen M. D. | | 23B. ADDRESS 4940 Eastern Avenue | | 23C. DATE SIGNED 8-21-50 | | | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/22/50 | | 24C. NAME OF CEMETERY OR CREMATORY Bak-Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) 7225 Eastern Ave Balto. Co. Md. | | | | | |
| DATE RECEIVED BY LOCAL REGISTRAR 8/21/50 | | REGISTRAR'S SIGNATURE William Williams, M.D. | | 25. FUNERAL DIRECTOR Charles S. Gile | | ADDRESS 901 S. Conkling St. | | | | | |

8

W. G. L. L.

R-246 50 7216

Roesler
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7216

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK C. ROESLER

2. DATE
OF
DEATH

Aug. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF

HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

St. Joseph's

c. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

3822 Foster Ave.

5. SEX

M.

6. COLOR OR RACE

M.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 21, 1877

9. AGE (In years
last birthday)

73

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Policeman

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Roesler

14. MOTHER'S MAIDEN NAME

Anna M. Schweiker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

212-10-3838

17. INFORMANT

ADDRESS

James F. Roesler 3822 Foster Ave.

18.

581.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Cirrhosis of liver

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1950 to Aug. 18, 1950, that I last saw the deceased alive on Aug. 18, 1950, and that death occurred at 4:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Thaddeus Sworski

23B. ADDRESS

M. D. 1400 N. Caroline St.

23C. DATE SIGNED

Aug. 18, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/22/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

4430 Belair Rd.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

Thaddeus Sworski

25. FUNERAL DIRECTOR

Charles S. Zeiler

ADDRESS

901 S. Conkling St.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

DATE: [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

1 - [Illegible]

50 7217

525
REA-139526

50 7217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Wesley Johnson (Welsley)

2. DATE
OF
DEATH

August 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTION

Baltimore City Hospitals

location)

4940 Eastern Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1349 N. Stricker Street

c. Length of stay in Baltimore

41 years

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 6, 1890

9. AGE (In years

last birthday)

60

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR
INDUSTRY

ODD JOBS

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Winfield Johnson

14. MOTHER'S MAIDEN NAME

Eleanor Ritshett (Pritchett)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18.

151X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinomatosis

Lyr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Carcinoma of stomach

Lyr

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1949

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of the stomach-found to be inoperable

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-7-1950, to 8-17-1950 that I last saw the
deceased alive on 8-17-1950 and that death occurred at 7:05 P. m., from the causes and on the date stated above.

23A. SIGNATURE

W. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-18-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)DATE RECEIVED BY
LOCAL REGISTRAR

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

REGISTRAR'S SIGNATURE

for William M.

25. FUNERAL DIRECTOR

Geo. S. Nelson / 303 Reservoir Dr.

ADDRESS

AUG 21 1950

VS 150

97099

46B

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "WATER" and "40" are faintly visible.]

8/20/20
The following is a list of the items
which were received from the
United States Department of the Interior
on August 20, 1920.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY E. WAGNER

2. DATE
OF
DEATH

AUG 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

SHRINER NURSING HOME
3520 HILTON ROAD.

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3712 FALLS ROAD

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months Days Hours Min.

FEMALE WHITE

WIDOW

MAR 12, 1871

79 YRS

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

HOUSEWORK

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

VIRGINIA.

U.S.

13. FATHER'S NAME

JOHN GUIDER

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MARGARET HEADLEY-3712 FALLS RD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

1 Hr.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 1, 1950 to Aug 19, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial Aug 22/50

Moreland Park

Taylor Ave Md

8/19/50

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

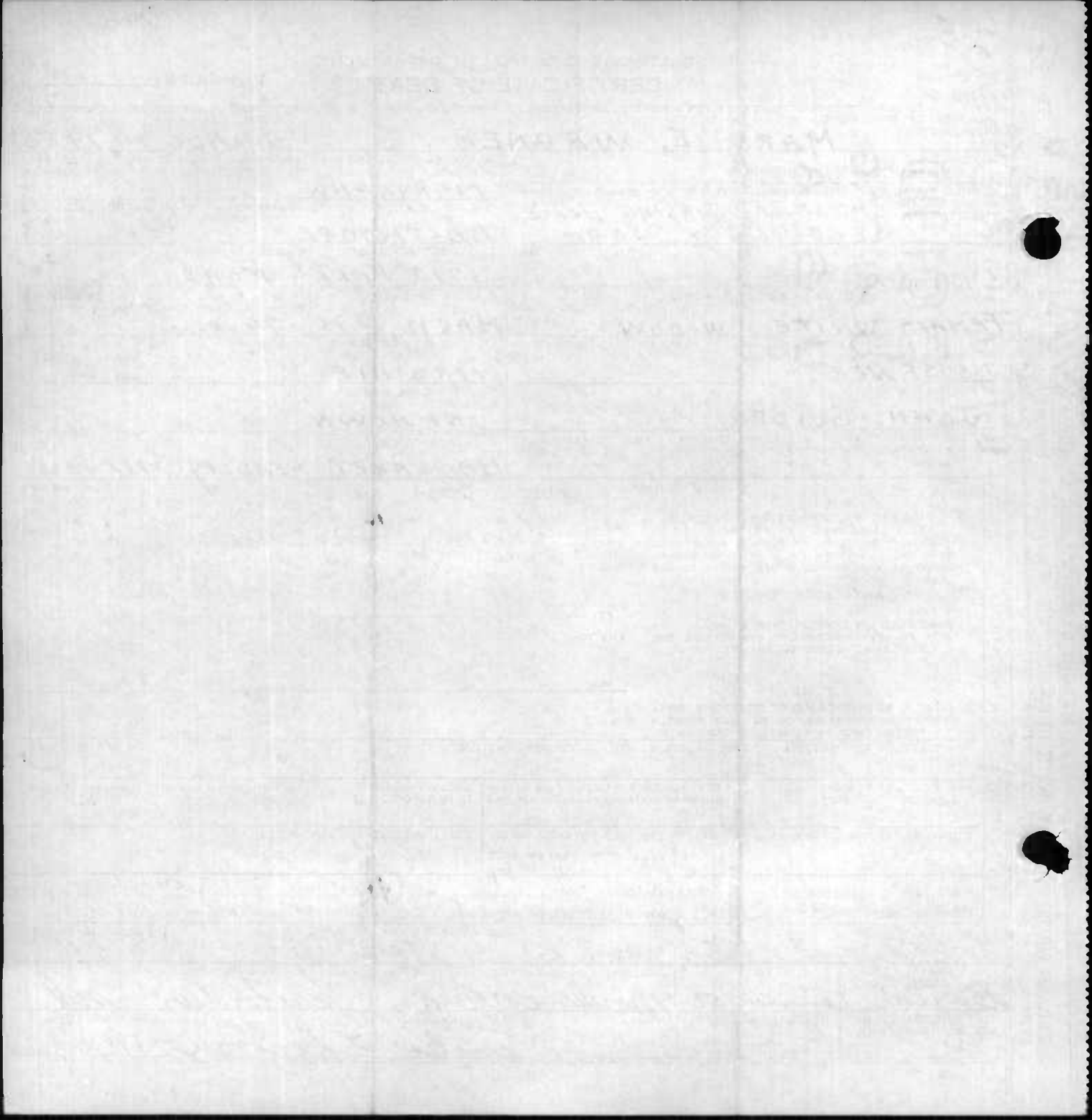
ADDRESS

AUG 21 1950

Theodore E. Honohan

3818 Roland

94a Ave



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Rosalie Sample

2. DATE
OF
DEATH

Aug. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION)

Little Sisters of the Poor Home for the Aged

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1200 Valley St

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years, last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Elder

14. MOTHER'S MAIDEN NAME

Sophie Litvinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT (Name and address)

1200 Valley St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CAUSE OF DEATH

Chronic Myocarditis
Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH

3 yrs
6 yr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Aug 15, 1950, that I last saw the deceased alive on Aug 10, 1950, and that death occurred at 7 A. M., from the causes and on the date stated above.

23A. SIGNATURE

E. Gill Hall

M. O.

23B. ADDRESS

1631 E North Ave

23C. DATE SIGNED

Aug-21-1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Aug 22/50

Cathedral

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

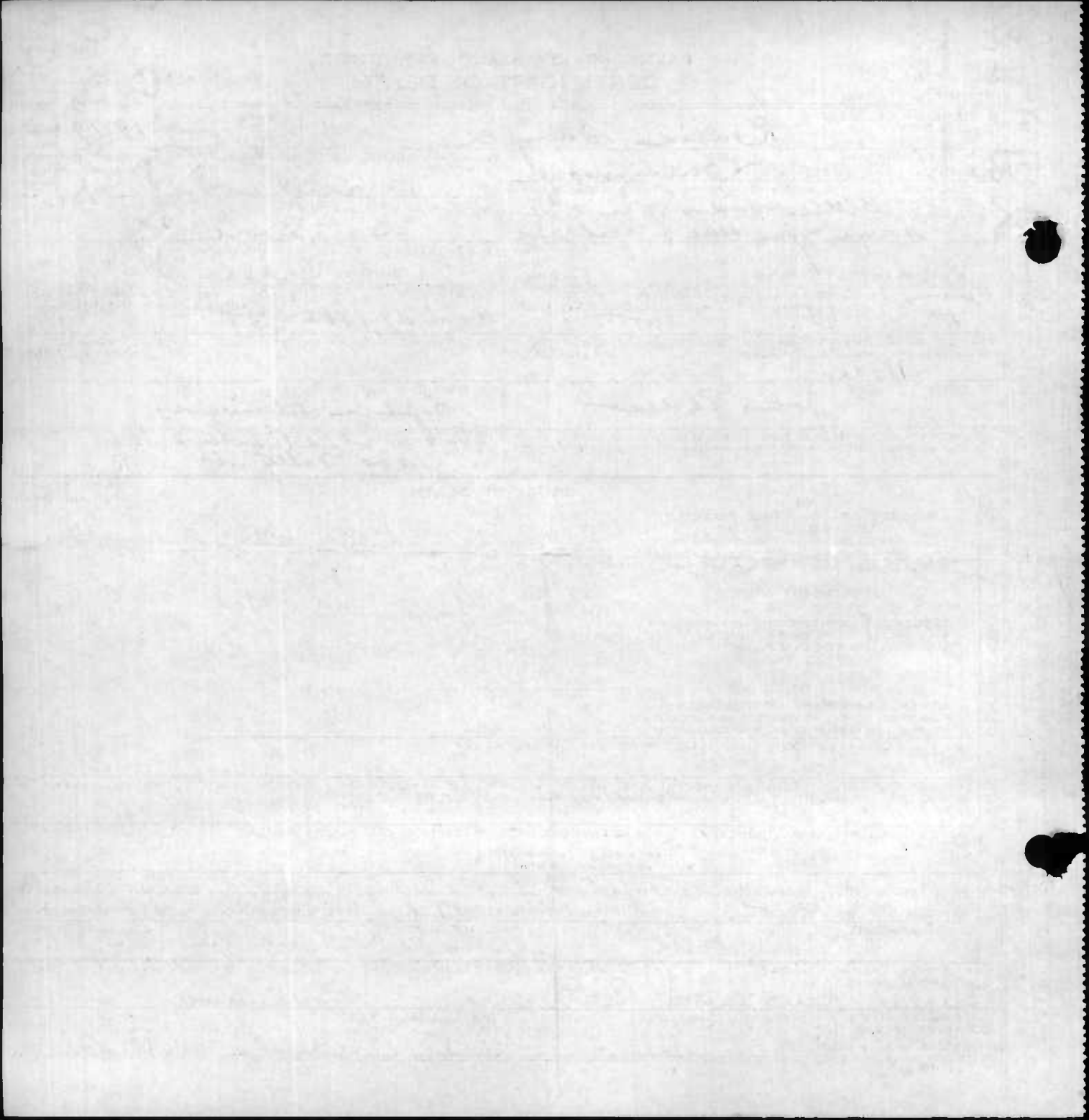
25. FUNERAL DIRECTOR

ADDRESS

AUG 21 1950

Huntington Williams, M.D.

Brida Weddefield 900 E Beadle St



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7220

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Kate Ford2. DATE
OF
DEATHAug. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

noneB. FULL NAME OF
HOSPITAL OR
INSTITUTION2117 Guilford Ave.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2117 Guilford Avenue

c. Length of stay in Baltimore

35 Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)single

8. DATE OF BIRTH

Feb. 14, 18709. AGE (in years
last birthday)80If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)none10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Harford County, Md.12. CITIZEN OF
WHAT COUNTRY?U. S.

13. FATHER'S NAME

George M. Ford

14. MOTHER'S MAIDEN NAME

Martha Louisa Shay15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS Grace, Md.Bennett S. Ford-347 Wilson St., Havre de18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary ThrombosisImmediate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Generalized ArteriosclerosisIndefinite

(C)

MyocarditisIndefiniteII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1924 to Aug. 21, 1950, that I last saw the
deceased alive on Aug. 14, 1950, and that death occurred at 6 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Nathaniel M. Beck

M. D.

23B. ADDRESS

St. Paul & 23rd St.

23C. DATE SIGNED

8-21-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)Burial

24B. DATE

8 - 23 - 50

24C. NAME OF CEMETERY OR CREMATORY

Spesutia

24D. LOCATION (City, town, or county)

Perryman, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRARAUG 21 1950

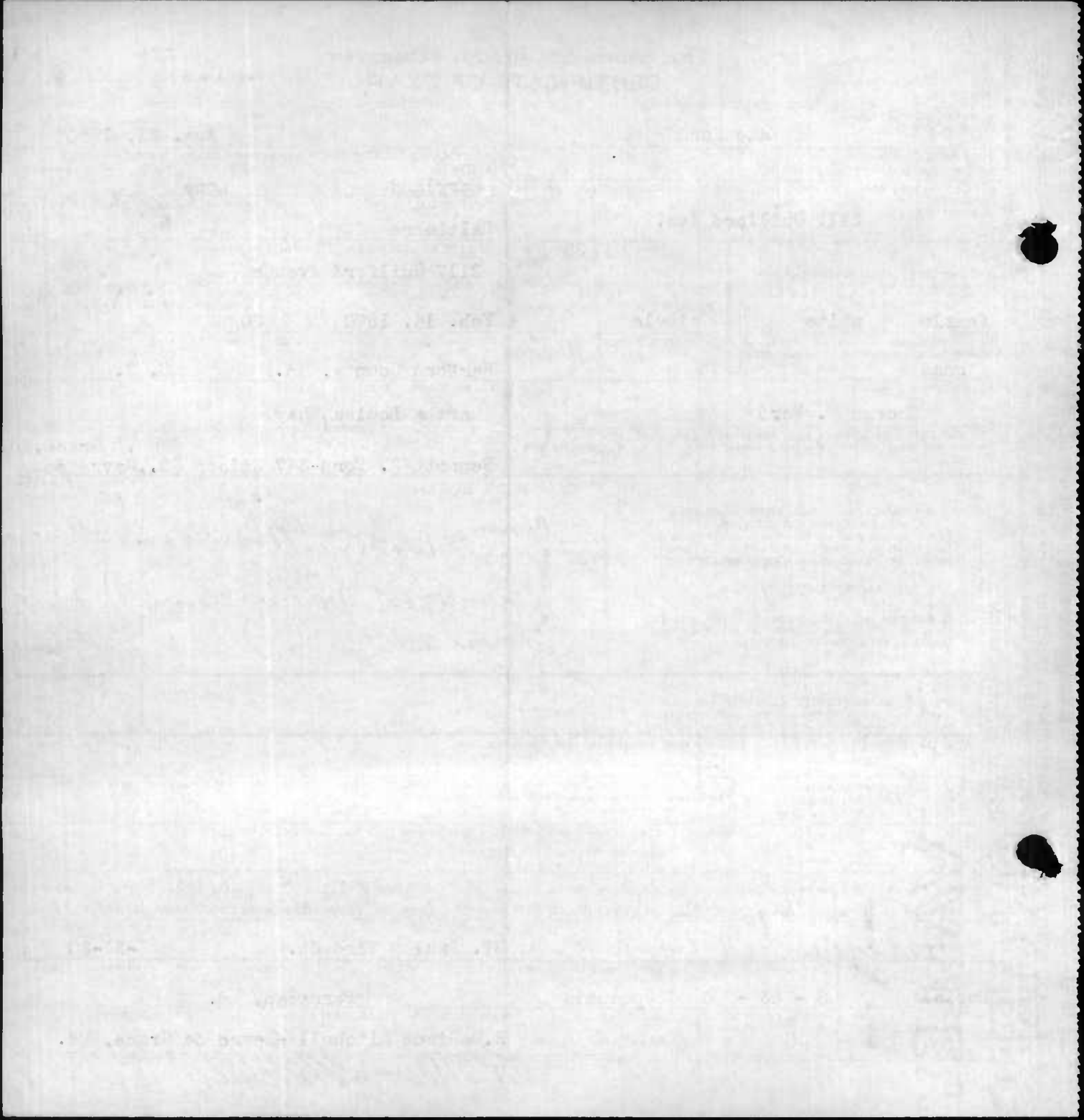
REGISTRAR'S SIGNATURE

Wm. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

R. Madison Mitchell - Havre de Grace, Md.R. Madison Mitchell93D



Issued Subject to approval and OK of "The Medical Examiner". 50 7221
BALTIMORE CITY HEALTH DEPARTMENT Per; Wm R. Boykin
CERTIFICATE OF DEATH Registered No.

BIRTH NO. 50 7221

| | | | |
|---|------------------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Jennie Craig</i> | | 2. DATE OF DEATH <i>Aug. 18, 1950</i> | |
| 3. PLACE OF DEATH A. Baltimore City Maryland | | 4. USUAL RESIDENCE (Where deceased lived, institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>1814 Mullin St</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-00</i> | |
| c. Length of stay in Baltimore <i>60 yrs.</i> | | D. STREET ADDRESS (If rural, give location) <i>1814 Mullin St.</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>May 21, 1884</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) <i>66</i> |
| 11. FATHER'S NAME <i>Washington Brown</i> | 12. CITIZEN OF WHAT COUNTRY? | | 11. BIRTHPLACE (State or foreign country) <i>Calvert County Md.</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME <i>Mary?</i> |
| 17. INFORMANT <i>Ida Dixon</i> | | ADDRESS <i>1307 W. 4th St.</i> | |

| | | | | | |
|---|--|---|--|--|--|
| 18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Embolism</i> | | CAUSE OF DEATH <i>Cardiovascular Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arterio Sclerosis</i> | | (A) DUE TO <i>Cardiovascular Disease</i> | | | |
| (B) DUE TO <i>Disease</i> | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>Aug. 18, 1950</i> , to <i>Aug. 18, 1950</i> , that I last saw the deceased alive on <i>Aug. 18, 1950</i> and that death occurred at <i>11 A</i> m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Wm R. Boykin</i> | | 23B. ADDRESS <i>1133 N. Monroe</i> | | 23C. DATE SIGNED <i>8/19/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Aug. 2/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>St. Stephens Cem. Ches. Md.</i> | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1950</i> | | REGISTRAR'S SIGNATURE <i>Washington Williams, Md.</i> | | 25. FUNERAL DIRECTOR <i>Mrs. Robert A. Elliott & Daughter</i> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOT A MEDICAL EXAMINER'S CASE

William V. Smith M.D.
CHIEF OR ASST. MEDICAL EXAMINER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7222BIRTH NO. 50 7222

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) MARION REINO GREEN | | | 2. DATE OF DEATH Aug. 19, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-05 | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOME | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City | | |
| c. Length of stay in Baltimore 35 years | | | D. STREET ADDRESS (If rural, give location) 3300 Chestnut Avenue | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug. 28, 1898 | 9. AGE (In years last birthday) 51 | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY Ship Yard | 11. BIRTHPLACE (State or foreign country) Carrollton, Carroll Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Marion Green | | | 14. MOTHER'S MAIDEN NAME Clara Reese | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO ***** | | 16. SOCIAL SECURITY NO. 219-03-0681 | 17. INFORMANT (wife) ADDRESS Mrs. Blanche Stocksdale Green 3300 Chestnut | | |

| | | | |
|--|--|--|---|
| 18. 4201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CORONARY Thrombosis DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 12 hours | | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from May 15, 1948 , to Aug 19, 1950 , that I last saw the deceased alive on Aug 17, 1950 , and that death occurred at 12 Pm. , from the causes and on the date stated above. | | | |
| 23A. SIGNATURE Archibald D. Davis | 23B. ADDRESS 800 W 33rd St | 23C. DATE SIGNED 8-20-1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 23, 1950 | 24C. NAME OF CEMETERY OR CREMATORY Sandy Mount Cemetery | 24D. LOCATION (City, town, or county) (State) Reisterstown, Md. |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1950 | REGISTRAR'S SIGNATURE James G. Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Company 108 W. North Ave. | |

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF VITAL RECORDS
WASHINGTON, D.C.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7223

BIRTH NO. 50 7223

| | | | | | |
|--|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Mrs. Helen Rider Hoen</i> | | | 2. DATE OF DEATH <i>August 20, 1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> | | | C. CITY OR TOWN (If outside corporate limits, write full name and give township) <i>Baltimore</i> | | |
| c. Length of stay in Baltimore <i>69</i> Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) <i>10 Midvale Rd.</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>July 31, 1881</i> | | 9. AGE (In years last birthday) <i>69</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Daniel Rider</i> | | | 14. MOTHER'S MAIDEN NAME <i>Helen Willson</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <i>DAUGHTER (MRS. HOEN) SAME</i> | | |

| | | | |
|--|---|--|--|
| 18. <i>154X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO | CAUSE OF DEATH <i>Carcinoma of Recto Sigmoid</i> <i>& Multiple Metastases</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>?</i> |
| | (B) DUE TO | | |
| | (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| | | | | | |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION <i>Aug 20, 1950</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>Aug. 16, 1950</i> , to <i>August 20, 1950</i> , that I last saw the deceased alive on <i>Aug. 20, 1950</i> , and that death occurred at <i>6:30 P.m.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Alvin Bongelaar</i> M. D. | | 23B. ADDRESS <i>Union Memorial Hosp</i> | | 23C. DATE SIGNED <i>Aug 20, 1950</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/22/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Lisville - Md.</i> | | 25. FUNERAL DIRECTOR <i>Stewart & Morley Co.</i> | | ADDRESS <i>461</i> | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 21 1950</i> | | REGISTRAR'S SIGNATURE <i>Mayor Thomas, Md</i> | | 25. FUNERAL DIRECTOR ADDRESS <i>108 W. North Av. - City 1</i> | |

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100-100000
100-100000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

St Agnes Hospital

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Daniel O'NEILL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

2. DATE OF DEATH

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

128 N. Symington Ave

8. DATE OF BIRTH

6-14-

9. AGE (In years last birthday)

67

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

17. INFORMANT

Husband

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) arterio-sclerotic C.V. Disease with adhesive Pericarditis

-DUE TO

Bilateral pleural effusion

(B)

and acute pulmonary edema

-DUE TO

terminal anemia and

(C)

diabetic coma

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/16, 1950, to 8/15, 1950 that I last saw the deceased alive on 8/15, 1950, and that death occurred at 3:50 PM from the causes and on the date stated above.

23A. SIGNATURE

John E. Healy M.D.

23B. ADDRESS

St Agnes Hosp

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/22/50

24C. NAME OF CEMETERY OR CREMATORY

New Catholic

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

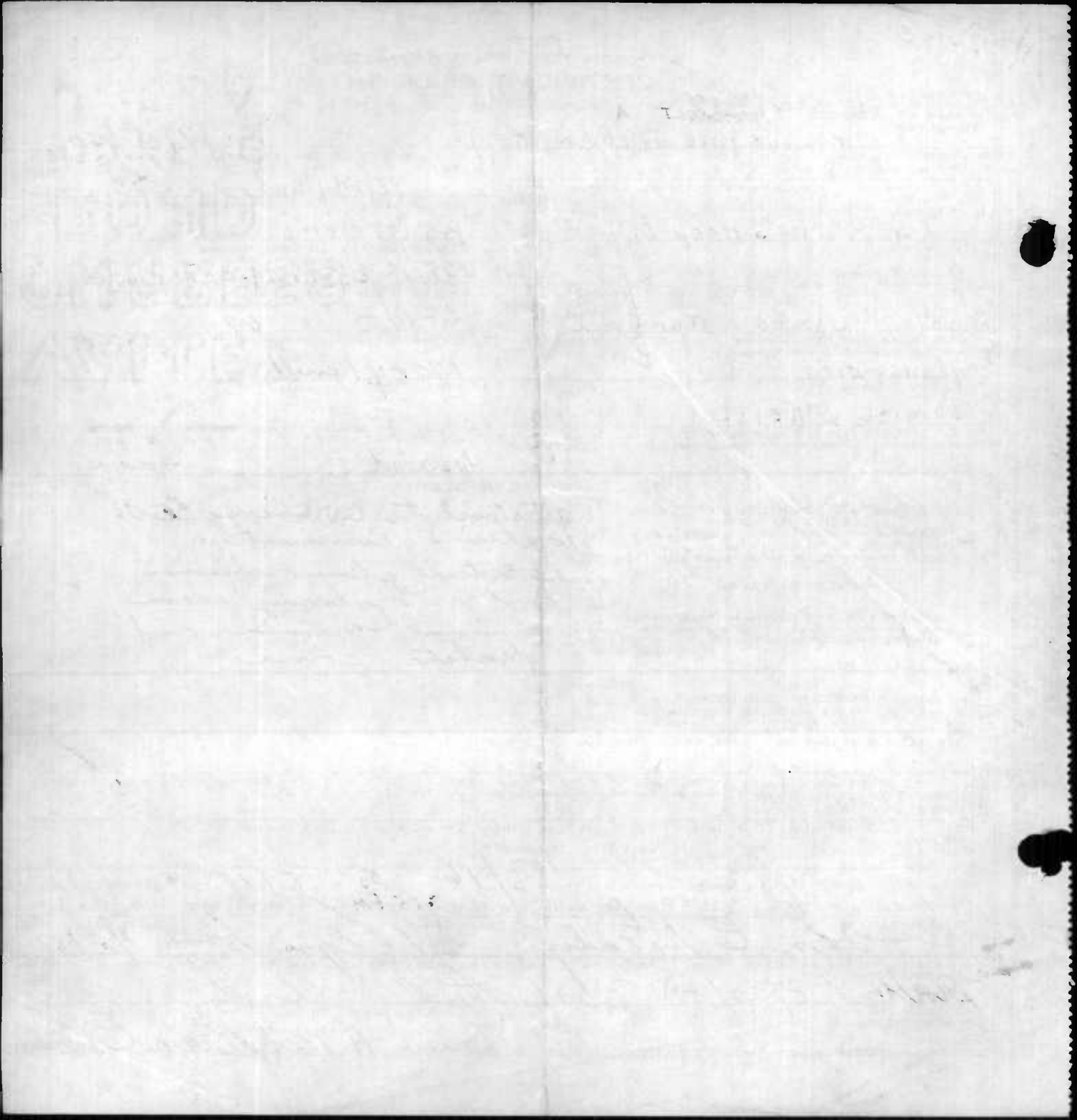
William H. Williams

25. FUNERAL DIRECTOR

Harry H. Witzke

ADDRESS

4101 Calverton



CERTIFICATE CORRECTED 8-21-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 7225

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John C.T. Wise

2. DATE
OF
DEATH

8/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

D. STREET ADDRESS (If rural, give location)

735 No. Lakewood Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

c. Length of stay in Baltimore

life

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married Widowed

8. DATE OF BIRTH

1-26-1885

9. AGE (In years last birthday)

65

10. Under 1 Year Months Days

6 23

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Gas & Electric Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George C.

14. MOTHER'S MAIDEN NAME

Albertine Walters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-05-7538

17. INFORMANT

Geo. C. Wise, son, 735 N. Lakewood Ave.

18. 420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Infarction; myocardial ducts
arteriosclerotic coronary thrombosis
(B) arteriosclerotic heart disease
DUE TO
(C) Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

Emoel W. Mintz

23B. ADDRESS

3004 Everside Ave

23C. DATE SIGNED

8/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 22, 1950

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Park Cem.

24D. LOCATION (City, town, or county) (State)

5806 Harford Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 21 1950

REGISTRAR'S SIGNATURE

Stanton William

25. FUNERAL DIRECTOR

Schmunk Funeral Home, Inc.

ADDRESS

2601-3-5 E. Madison St.

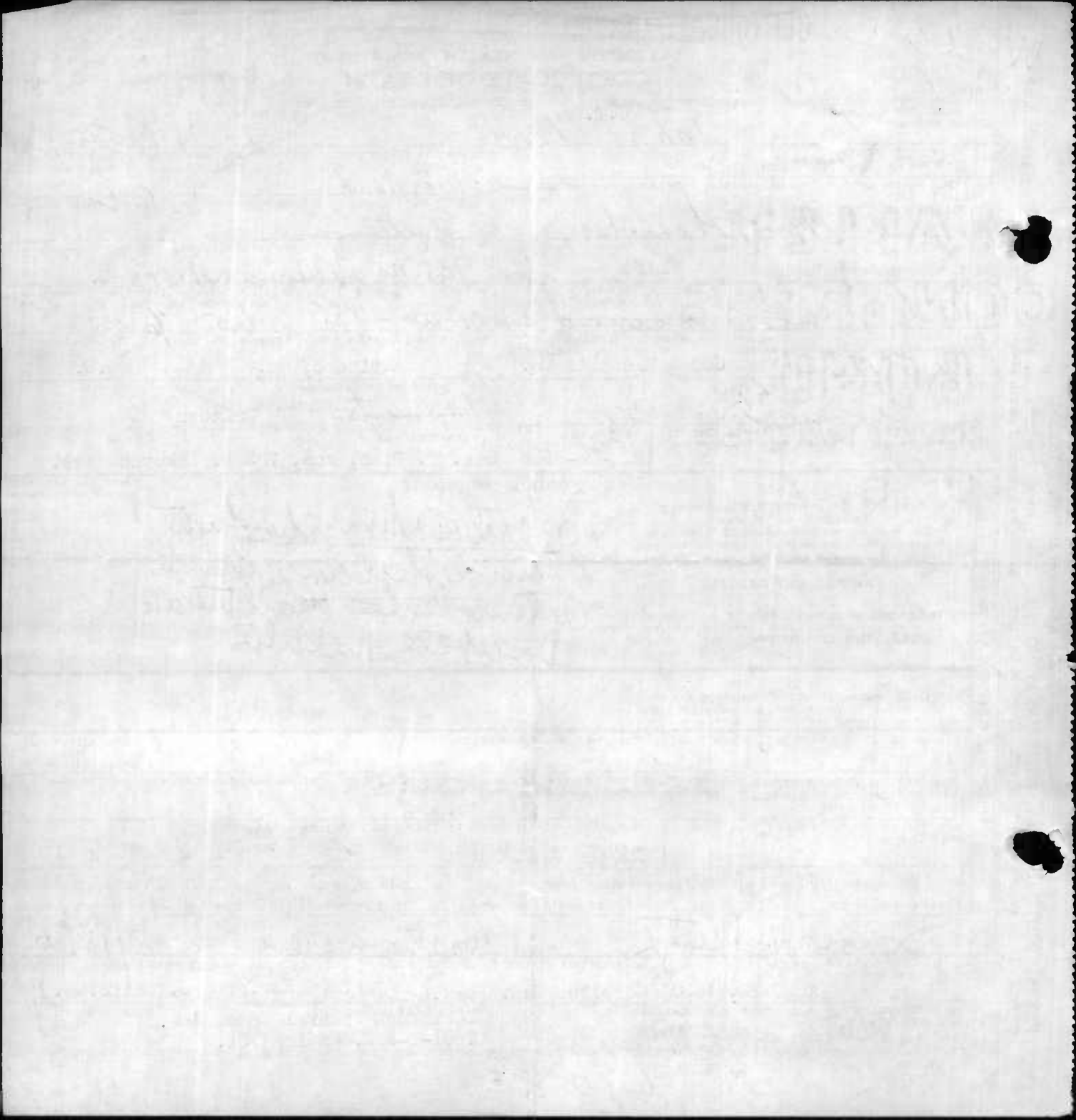
VS 150

6905E

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7226

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Roberta Thompson | | 2. DATE OF DEATH Aug. 20, 50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Ind. B. COUNTY St. Mary's | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION JOHN HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Valley Lee | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 6800 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 7-27-22 |
| 9. AGE (in years last birthday) 28 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY FOR FAMILY | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | 13. FATHER'S NAME Louis Campbell | 14. MOTHER'S MAIDEN NAME Maud Mason | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS JOHN HOPKINS HOSPITAL | |
| 18. 019.2 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Miliary Tuberculosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 1 month |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug. 19, 1950 , to Aug 20, 1950 , that I last saw the deceased alive on Aug 20, 1950 and that death occurred at 1:45 p.m., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE Thomas J. Walsh M. D. | | 23B. ADDRESS JOHN HOPKINS HOSPITAL | |
| 23C. DATE SIGNED | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE Aug 23, 1950 | 24C. NAME OF CEMETERY OR CREMATORY ST. GEORGES | 24D. LOCATION (City, town, or county) (State) VALLEY LEE MD. |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1950 | REGISTRAR'S SIGNATURE Winston Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS JOS. C. MATTINGLEY LEONARDTOWN MD. | |

100

Robertson

100

100

100

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100

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100

100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TIBERIUS
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7227

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joe Tiberius

2. DATE
OF
DEATH

8/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

15 Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1888

9. AGE (In years
last birthday)

68

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Hand operator

10B. KIND OF BUSINESS OR
INDUSTRY

Tailoring

11. BIRTHPLACE (State or foreign country)

LITHUANIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

216-03-180944

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) ...

Antemortem C.V. disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) ...

(C) ...

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

P. J. Sulmasy

23B. CHIEF MEDICAL EXAMINER..... ☐

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER..... ☐

8/19/50

MEDICAL INVESTIGATOR..... ☐24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

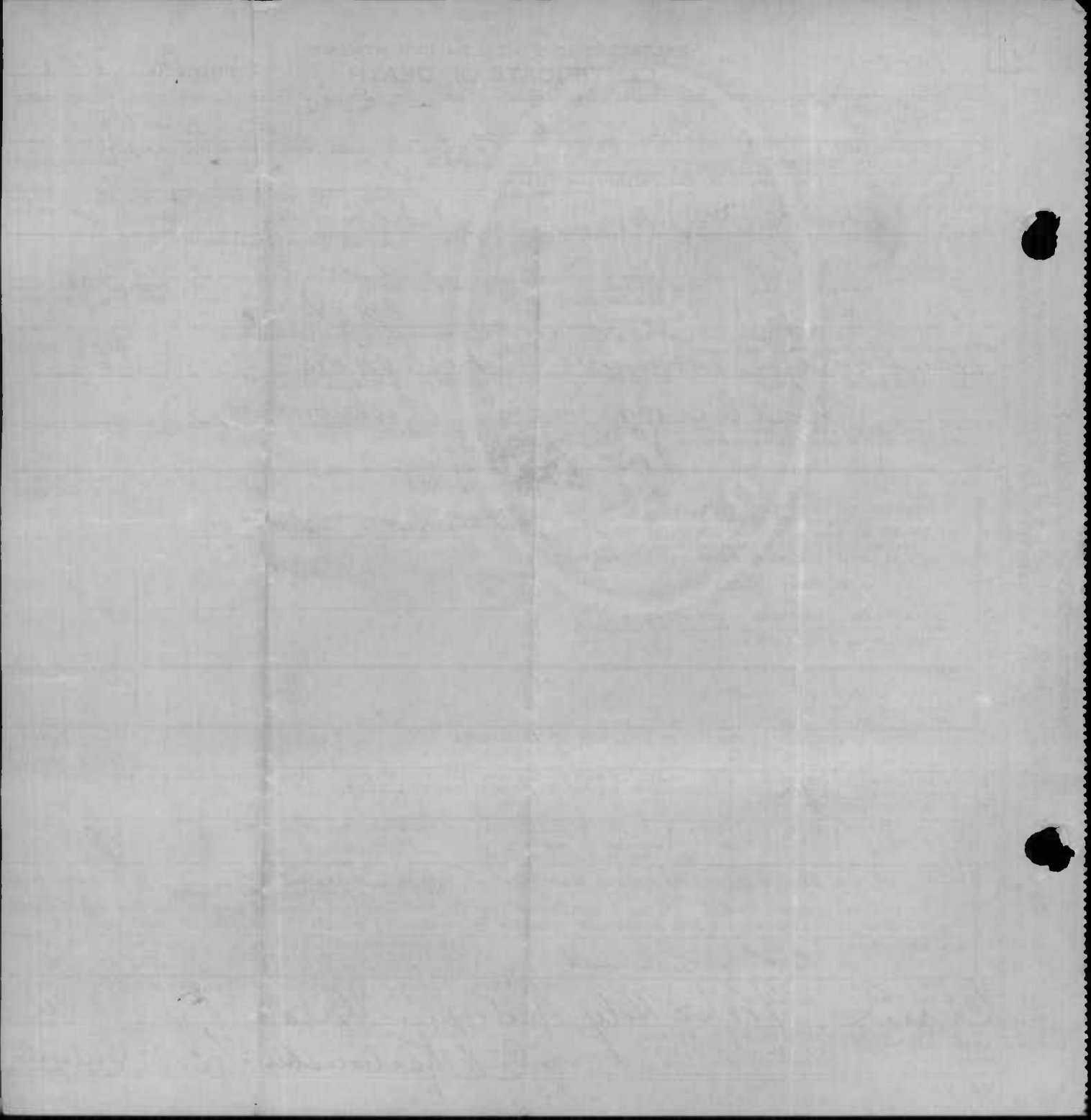
25. FUNERAL DIRECTOR

ADDRESS

VS 151

69044

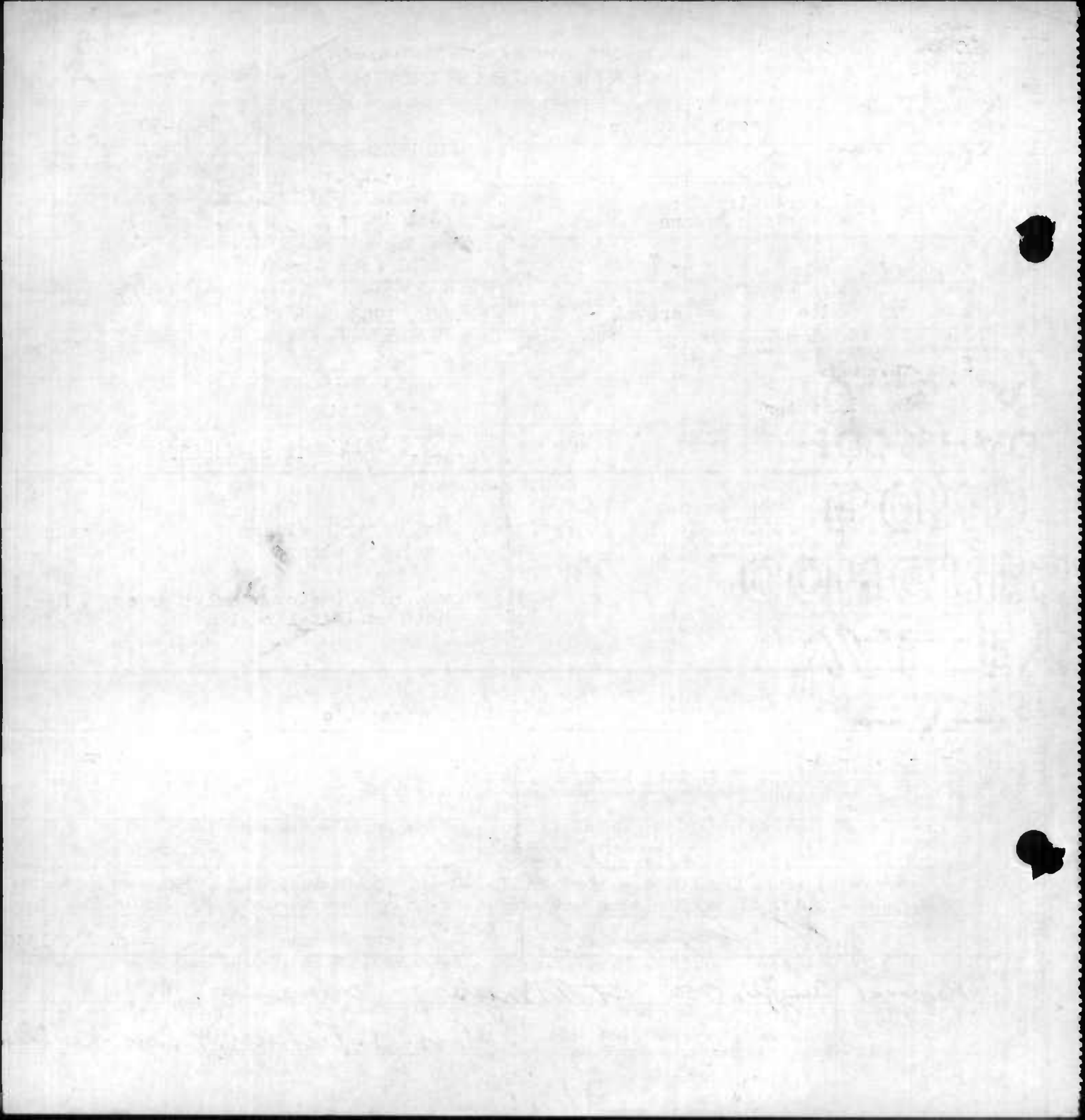
935



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| | | | | | |
|---|---------------------------|---|---|---|---|
| 536 LC 134992 50 7228 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 50 7228 Registered No. | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Joseph Lanthier | | | 2. DATE OF DEATH 8-21-50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue 31 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-01 D. STREET ADDRESS (If rural, give location) 1501 John Street | | |
| c. Length of stay in Baltimore 10 Years Yrs. Mos. Days | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated | 8. DATE OF BIRTH Feb. 23, 1903 | 9. AGE (In years last birthday) 42 | 10 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME John Lanthier | | | 14. MOTHER'S MAIDEN NAME Mary Walling | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Records* Baltimore City Hospitals 4940 Eastern Avenue | | |
| 18. 193X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | CAUSE OF DEATH (A) Perforation of gastric ulcers (Cushing's ulcer) DUE TO 2 Weeks (B) Brain tumor, glioblastoma multiforme DUE TO left parieto occipital region 8 Mos. (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Pneumonitis, hypostatic | | |
| 19A. DATE OF OPERATION 1-20-50, 8-10-50 3 | | 19B. MAJOR FINDINGS OF OPERATION Brain Tumor | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Jan. 16, 1950 to Aug. 21, 1950, that I last saw the deceased alive on Aug. 21, 1950, and that death occurred at 5:20 AM, from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE J. J. Cohen | | 23B. ADDRESS 4940 Eastern Avenue | | 23C. DATE SIGNED Aug. 21, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24B. DATE Aug 21, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY St. Mary's | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 24E. NAME OF CEMETERY OR CREMATORY St. Mary's | | 24F. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE Wm. J. Tickner | | 25. FUNERAL DIRECTOR ADDRESS Wm. J. Tickner & Sons - Baltimore | |
| AUG 21 1950 51599 54a | | | | | |



15-42 50 7229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7229
Registered No.

| | | | | | |
|--|------------------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) JOHN KROLICKI | | 2. DATE OF DEATH Aug 20 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-01 | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION S. Balt. General Hospital | | D. STREET ADDRESS (If rural, give location) 2800 Block E Haylett St | | c. Length of stay in Baltimore Yrs. Mos. Days | |
| 5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Apr 23 1888 | 9. AGE (In years last birthday) 62 | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Mid Dry Dock | | 11. BIRTHPLACE (State or foreign country) Austria Hungary | |
| 13. FATHER'S NAME John Krolicki | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 218-09-6776 | | 17. INFORMANT ADDRESS Stanley Krolicki, 206 E Red St | |

18. **E 812.4**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
External hemorrhage
Compound fracture of left leg
Fracture of skull

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH
(A) **External hemorrhage**
DUE TO **Compound fracture of left leg**
(B) **Fracture of skull**
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | | | | |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION Aug 20 1950 | | 19B. MAJOR FINDINGS OF OPERATION Street | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hanover Street near bridge | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 20, 1950 12:30A. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Was pushing his car. Hit by hit + run driver. | |

22. I certify that I took charge of the remains described above, held an **Inspection and Inquiry** thereon and from the evidence obtained by said **Autopsy, Inspection or Inquiry**, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

| | | | | | |
|--|--|---|--|---|--|
| 23A. SIGNATURE Stanley K. Dunsberger | | 23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR..... | | 23C. DATE SIGNED August 20, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 24B. DATE 8/28/50 | | 24C. NAME OF CEMETERY OR CREMATORY St. Petrus | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. LOCATION (City, town, or county) Baltimore | | 24F. LOCATION (City, town, or county) Baltimore | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS 1219 St Paul St | |

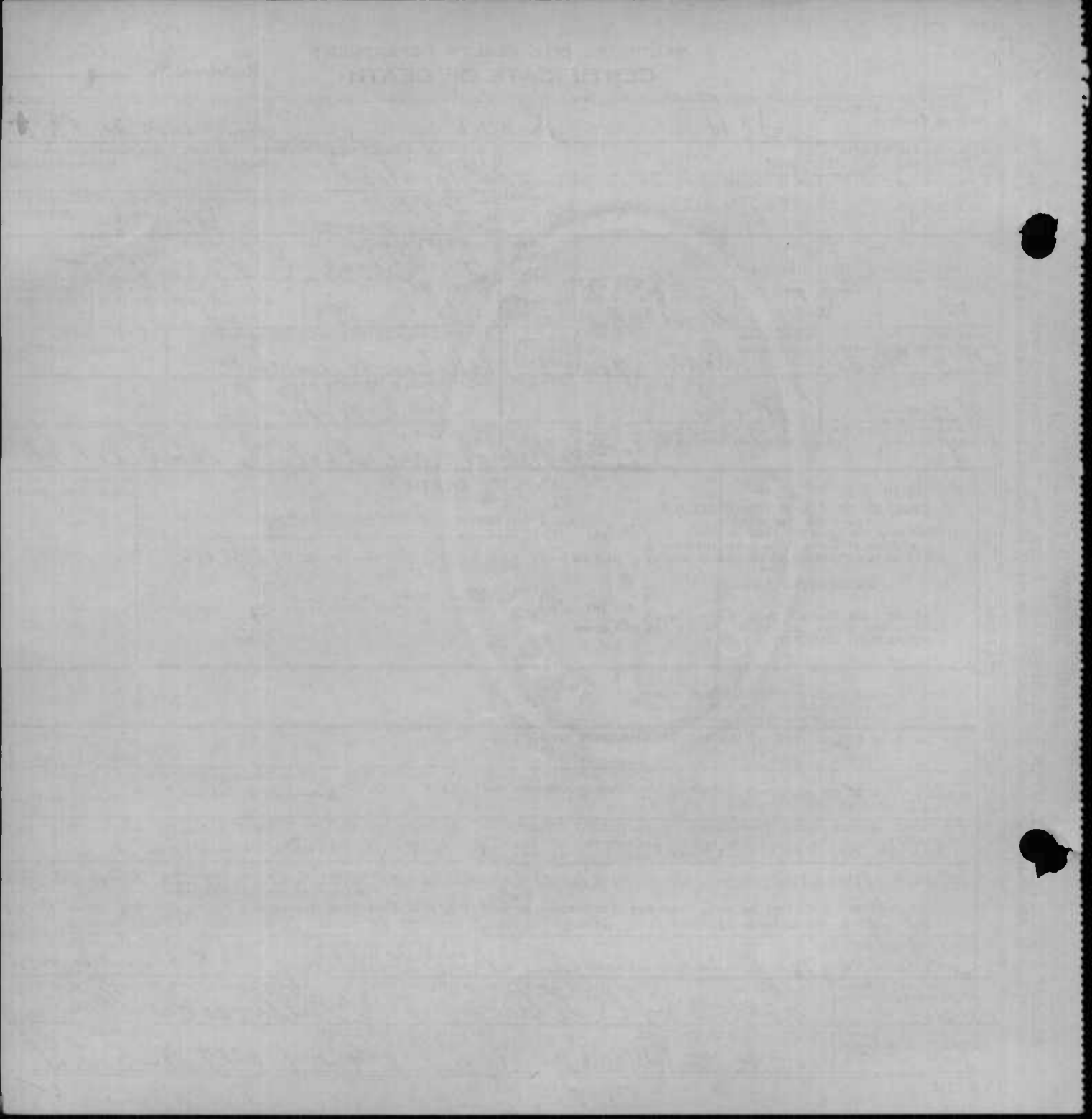
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7230
8/20/50 12.05 A.M.
8/19/50 #445
#445 P.M.

| | | |
|---|----------------------------------|---|
| BIRTH NO. | | |
| 1. NAME OF DECEASED (Type or Print) <i>Lawrence J. McHale</i> | | 2. DATE OF DEATH <i>8/19/50</i> |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1704 N. Milton Ave</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 8-02</i> |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) <i>1704 N. Milton Ave</i> |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Fire Dept</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Balto</i> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <i>Martin J. McHale</i> | | 14. MOTHER'S MAIDEN NAME <i>Delia B. Holmes</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>W.W. #1</i> |
| 17. INFORMANT <i>Thos. M. McHale</i> | | 18. ADDRESS <i>543 E. 38th St</i> |

| | | |
|--|---|----------------------------------|
| 18. <i>180X</i> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | (A) <i>Carcinoma of lungs + liver</i> DUE TO | <i>Two months</i> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) <i>Carcinoma of right kidney</i> DUE TO | <i>Seven months</i> |
| (C) <i>None</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|--|---|
| 19A. DATE OF OPERATION <i>None</i> | 19B. MAJOR FINDINGS OF OPERATION <i>None</i> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from *June 10, 1950*, to *Aug 20, 1950*, that I last saw the deceased alive on *Aug 20, 1950*, and that death occurred *12.05 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE
Frank H. O'Brien

23B. ADDRESS
2701 N. Calvert St.

23C. DATE SIGNED
Aug 21, '50

| | | | |
|--|-----------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>8/23/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>U. S. National</i> | 24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i> |
|--|-----------------------------|---|--|

| | | | |
|--|---|--|---------|
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 22 1950</i> | REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>Wm Cook Inc. 1217 St. Paul St</i> | ADDRESS |
|--|---|--|---------|

10

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Ethel May Hutton

2. DATE
OF
DEATH

Aug. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland* B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4634 Rokeby Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 28-04

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

4634 Rokeby Road

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 1896

9. AGE (In years last birthday)

54

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

Insurance Statistician

10B. KIND OF BUSINESS OR INDUSTRY

U.S. F.I.

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter Warner

14. MOTHER'S MAIDEN NAME

Laura Weston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Carlton A. Hutton, 4634 Rokeby Rd

ADDRESS

18. *422.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Ventricular tachycardia*
DUE TO *Arteriosclerotic cardio-vascular disease with myocarditis.*
(B) *Cardiac dilatation.*
DUE TO _____
(C) _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *15 May, 1950* to *20 Aug, 1950*, that I last saw the deceased alive on *20 Aug, 1950*, and that death occurred at *6:20 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Emil H. Henning Jr.

23B. ADDRESS

601 Winans Way

23C. DATE SIGNED

21 Aug 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine

24D. LOCATION (City, town, or county) (State)

Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 22 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

W. C. Inc 1219 St Paul

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7232
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Anthony Wincos

2. DATE OF DEATH *8-20-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1606 Cereal St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

25-05

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

O. STREET ADDRESS (If rural, give location)

1606 Cereal St.

C. Length of stay in Baltimore *Fifty Years*

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (In years last birthday)

76

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Anthony J. Wincos 1606 Cereal St.

1B.

422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Arteriosclerotic C. V. disease*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug 19*, 19*50*, to _____, 19____, that I last saw the deceased alive on *Aug 19*, 19*50*, and that death occurred at *11 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

Henry R. Gehlert

23B. ADDRESS

M. D.

4700 Pennington Ave.

23C. DATE SIGNED

8-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Aug 22 1950

Washington Williams

Fred W. Ogazowski 937

VS 150

1930 Eastern Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Sidney
Wheeler

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age, is especially important. Physicians: please write the causes of death clearly, and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|----------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) William L. Parker | | | 2. DATE OF DEATH Aug. 20, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 1913 Eutaw Place | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Twilight Nursing Home | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-01 | | |
| c. Length of stay in Baltimore 40 yrs. | | | D. STREET ADDRESS (If rural, give location) 1913 Eutaw Place/ | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced | 8. DATE OF BIRTH Oct. 10, 1882 | 9. AGE (In years last birthday) 67 | 10. Under 1 Year Months: 8 Days: 10 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barge Master | | | 10B. KIND OF BUSINESS OR INDUSTRY Coast Guard | | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | | 12. CITIZEN OF WHAT COUNTRY? ✓ | | |
| 13. FATHER'S NAME Joseph A. Parker | | | 14. MOTHER'S MAIDEN NAME Madeline Weld | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 217-14-9932 | | |
| 17. INFORMANT Mrs. Wilber Fowler | | | ADDRESS 7125 Harford Rd | | |

| | | | | | |
|--|--|--|---|---|--|
| 18. 490x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, rt. lower lobe | | | CAUSE OF DEATH Interval between onset and death 2 days | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Seizure | | | (B) _____ DUE TO _____ | | |
| (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug 20 , 19 50 , to Aug 21 , 19 50 , that I last saw the deceased alive on Aug 21 , 19 50 , and that death occurred at 1:45 p.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE E. R. Smith | | 23B. ADDRESS 2831 Maryland Ave | | 23C. DATE SIGNED 8-21-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 22, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Mount Carmel | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. FUNERAL DIRECTOR Thurston Williams, Inc. | | 24F. ADDRESS 1902 Eutaw Place. | |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1950 | | 24H. REGISTRAR'S SIGNATURE Thurston Williams, Inc. | | 24I. FUNERAL DIRECTOR Thurston Williams, Inc. | |

TO THE SECRETARY, U. S. DEPARTMENT OF AGRICULTURE

FROM

DATE

SUBJECT

REMARKS

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. [illegible]

29. [illegible]

30. [illegible]

31. [illegible]

32. [illegible]

33. [illegible]

34. [illegible]

35. [illegible]

36. [illegible]

37. [illegible]

38. [illegible]

39. [illegible]

40. [illegible]

41. [illegible]

42. [illegible]

43. [illegible]

44. [illegible]

M 263
50 7234MacCarthy
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7234

| | | | | | | | |
|--|----------------------------------|---|---|---|--|---|--|
| BIRTH NO. | | | | 2. DATE OF DEATH 8/21/50 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Roselee MacCarthy</u> | | | | 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore, Maryland</u> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>12-02</u> | | | |
| c. Length of stay in Baltimore <u>9</u> Yrs. Wks. Days | | | | D. STREET ADDRESS (If rural, give location) <u>3019 Guilford Avenue</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 13 1895</u> | | 9. AGE (In years last birthday) <u>55</u> | If Under 1 Year Months Days If Under 24 Hours Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James V. Hughes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah McKean</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>112-10-3936</u> | | 17. INFORMANT ADDRESS <u>Hospital Record</u> | | | |
| 18. <u>584X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary thrombosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Chronic Cholecystitis + Cholelithiasis</u> | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>8/21/50</u> | | 19B. MAJOR FINDINGS OF OPERATION <u>Chronic cholecystitis</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>8/20/50</u> , 19 <u> </u> , to <u>8/21/50</u> , 19 <u> </u> , that I last saw the deceased alive on <u>8/21/50</u> , 19 <u> </u> , and that death occurred at <u>2:05 P. m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23A. SIGNATURE <u>William B. Cooper, M.D.</u> | | | | 23B. ADDRESS <u>1213 Light Street</u> | | 23C. DATE SIGNED <u>8/21/50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24B. DATE <u>Aug 22 1950</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u> | | 24D. LOCATION (City, town, or county) (State) <u>Brooklyn N.Y.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 22 1950</u> | | REGISTRAR'S SIGNATURE <u>William B. Cooper, M.D.</u> | | 25. FUNERAL DIRECTOR ADDRESS <u>Henry H. Jenkins & Sons</u> <u>4905 York Rd</u> | | | |

RECEIVED

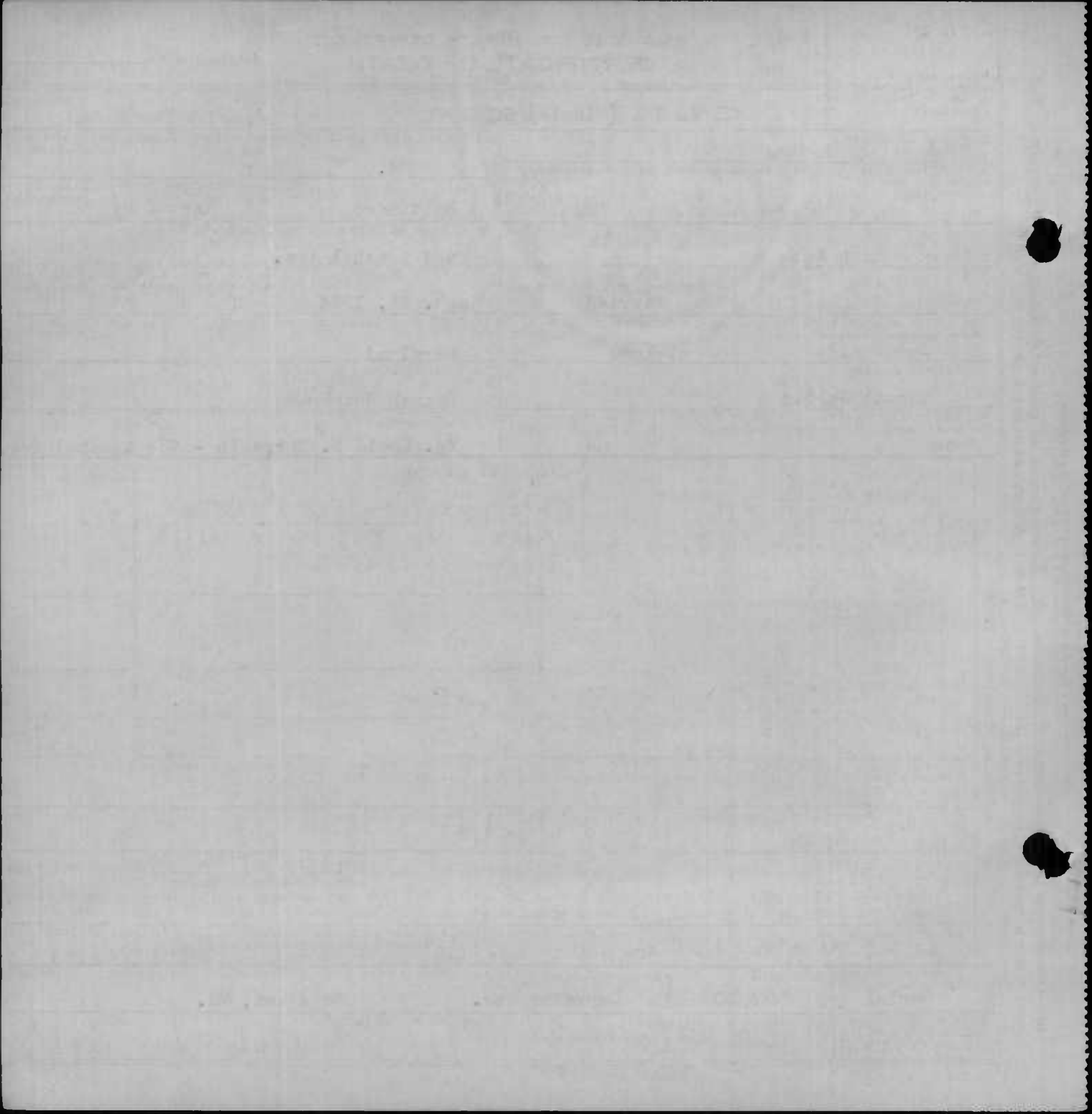
CERTIFICATE OF DEATH

RECEIVED

RECEIVED

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7235

| | | | |
|--|-------------------------------|--|---|
| BIRTH NO. <u>50 7235</u> | | 2. DATE OF DEATH <u>Aug. 20, 1950</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>WILHELMINA (Minnie) SCHNEPFE</u> | | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital (DCH)</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>25-04</u> | |
| c. Length of stay in Baltimore Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u> | | D. STREET ADDRESS (If rural, give location) <u>424 Annabel Ave.</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Sept. 23, 1884</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 9. AGE (In years last birthday) <u>65</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>August Walter</u> | | 14. MOTHER'S MAIDEN NAME <u>Hannah Buschman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>Mr. Louis H. Schnepfe</u> | | ADDRESS <u>424 Annabel Ave.</u> | |
| 18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardio-Vascular Disease with Decompensation</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I took charge of the remains described above, held an <u>Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | |
| 23A. SIGNATURE <u>Wm. H. Rammer, Jr.</u> | | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. <u>Aug. 20, 1950</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/23/50</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 22 1950</u> | | REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u> | |
| 25. FUNERAL DIRECTOR <u>Wm. J. Pickens & Sons</u> | | ADDRESS <u>Beth</u> | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7236

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary O. Hackney

2. DATE
OF
DEATH

8/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 27-11

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

4910 Crowson Avenue #12

5. SEX

F

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

4-21-1874

9. AGE (In years
last birthday)

76

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Franklin Reed

14. MOTHER'S MAIDEN NAME

M. Elizabeth Wilkens

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs Ed Smith 206 St. ...

ADDRESS

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Posterior myocardial
infarction

25 days

ANTECEDENT CAUSES

(B)

DUE TO

Antihypertensive Heart
Disease

unknown

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/31, 1950, to 8/20, 1950, that I last saw the
deceased alive on 8/20, 1950, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Marymild Louisa ...

23B. ADDRESS

M. D. of General Hosp

23C. DATE SIGNED

8/20/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland.

(State)

DATE RECEIVED BY
REGISTRAR

AUG 22 1950

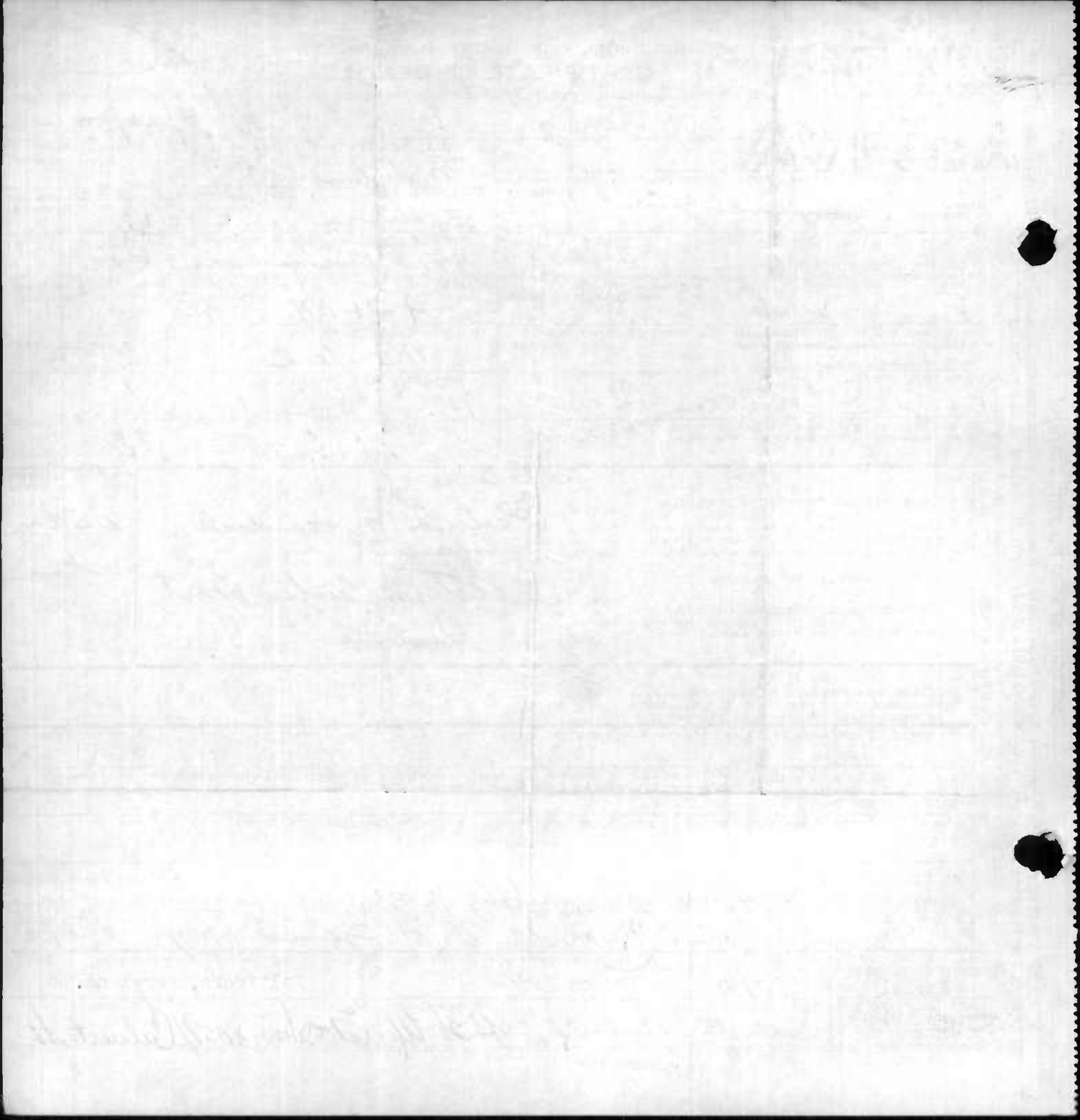
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

H. H. ... 8057 Calvert St.

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 7237

 BIRTH NO. 50 7237

 1. NAME OF DECEASED (Type or Print) LEO JOSEPH WILLIAMS

 2. DATE OF DEATH August 20, 1950

 3. PLACE OF DEATH:
A. Baltimore City, Maryland

 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY _____

 B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Marine Hospital
Wyman Pk. Drive & 31st St.

 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 7-03

 c. Length of stay in Baltimore 1 day Yrs. _____ Mos. _____ Days _____

 D. STREET ADDRESS (If rural, give location)
813 N. Bradford St.

 5. SEX
M

 6. COLOR OR RACE
W

 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

 8. DATE OF BIRTH
5/23/23

 9. AGE (In years last birthday) 27 If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____

 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
seaman

 10B. KIND OF BUSINESS OR INDUSTRY
Seafarer

 11. BIRTHPLACE (State or foreign country)
Md.

 12. CITIZEN OF WHAT COUNTRY?
USA

 13. FATHER'S NAME
William Williams

 14. MOTHER'S MAIDEN NAME
Mamie Brock

 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW 2- USN

 16. SOCIAL SECURITY NO.
214-16-9660

 17. INFORMANT ADDRESS
Records- US Marine Hospital, Balto, Md.

 18. 330X1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

 (A) Subarachnoid hemorrhage
9 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

 (B) Ruptured aneurysm of circle of Willis
Unknown

DUE TO

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

 19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

 YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

 22. I hereby certify that I attended the deceased from Aug. 17, 1950 to Aug. 20, 1950 that I last saw the deceased alive on Aug. 20, 1950 and that death occurred at 7:33Pm. from the causes and on the date stated above.

 23A. SIGNATURE John L. Wilson
John L. Wilson, Medical Director M. D.

 23B. ADDRESS US Marine Hospital, Balto, Md.

 23C. DATE SIGNED 8/21/50

 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

 24B. DATE Aug 24/50

 24C. NAME OF CEMETERY OR CREMATORY M. D. Bald Nat. Cem

 24D. LOCATION (City, town, or county) (State) Baltimore Md

 DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1950

 REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Philip's Herwig Sons 2024 Orleans St

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|---|--|---------------------------------|--|
| <p>1. Name of Deceased</p> | | <p>2. Sex</p> | | <p>3. Age</p> | |
| <p>4. Date of Birth</p> | | <p>5. Place of Birth</p> | | <p>6. Date of Death</p> | |
| <p>7. Cause of Death</p> | | <p>8. Manner of Death</p> | | <p>9. Place of Death</p> | |
| <p>10. Signature of Registrar</p> | | <p>11. Signature of Medical Officer</p> | | <p>12. Signature of Coroner</p> | |

| | | | |
|------------------------------------|--|---|--|
| <p>13. Name of Registrar</p> | | <p>14. Signature of Registrar</p> | |
| <p>15. Name of Medical Officer</p> | | <p>16. Signature of Medical Officer</p> | |
| <p>17. Name of Coroner</p> | | <p>18. Signature of Coroner</p> | |

| | | | |
|------------------------------------|--|---|--|
| <p>19. Name of Registrar</p> | | <p>20. Signature of Registrar</p> | |
| <p>21. Name of Medical Officer</p> | | <p>22. Signature of Medical Officer</p> | |
| <p>23. Name of Coroner</p> | | <p>24. Signature of Coroner</p> | |

B-526
50 7238

CERTIFICATE CORRECTED 8-22-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7238

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SOPHIE

T.

BAUMGARTEN
BAUMGARTNER-2. DATE
OF
DEATH

August 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

Yrs.
Mos.
Days

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

5/11/1919

9. AGE (In years
last birthday)

31

11 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

PITTSBURGH, PA.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

MICHAEL MATSKUH

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

LEO J. BAUMGARTEN 715 HANOVER ST. -30

18. E816.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Intraperitoneal hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)
Street21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Ordinance Depot Road & Ritchie Highway

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 19, 1950 1:25A.m.

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto and auto collision

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley N. Doulacher

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

8-19-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

HOLY CROSS

24D. LOCATION (City, town, or county)

RITCHIE HIGHWAY

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JOAN F. DENNY, INC 715 LIGHT ST -30

RECEIVED BY THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

OFFICE OF THE SECRETARY

100-100000

100-100000

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7239

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Erhardt

2. DATE
OF
DEATH

Aug. 20, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Ind.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - 26-44

D. STREET ADDRESS (If rural, give location)

3405 Noble St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9-6-85

9. AGE (in years
last birthday)

64 6.5

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Edmonds

14. MOTHER'S MAIDEN NAME

Lucy E. Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Coronary Artery Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hypertensive & Arteriosclerotic
DUE TO Cardiovascular disease

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 18, 1950 to Aug. 20, 1950 that I last saw the
deceased alive on Aug. 20, 1950 and that death occurred at 5 P. M., from the causes and on the date stated above.

23A. SIGNATURE

A. H. Owens, Jr.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Aug 23/50

24C. NAME OF CEMETERY OR CREMATORY

Bald Cem

24D. LOCATION (City, town, or county)

Bald Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

L. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ulrich Funeral Home 2004 Calver

Eligibility Certificate

For

Admission

to the

Class of

1902-1903

of the

University of

Chicago

is hereby

granted to

the

Class of

1902-1903

of the

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7240

BIRTH NO. 50 7240

1. NAME OF DECEASED
(Type or Print) ELIZABETH Rumpf

2. DATE OF DEATH August 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-09

C. Length of stay in Baltimore LIFE

D. STREET ADDRESS (If rural, give location) 1118 E. Lanvale St. Baltimore

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH April 16, 1883

9. AGE (In years last birthday) 67 yrs.

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John P. Rumpf

14. MOTHER'S MAIDEN NAME Anna Yeager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Marjorie Rumpf ADDRESS 1118 E. Lanvale

18. 151X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of stomach with metastases to spine, liver, and supraclavicular lymph nodes.

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3, 1950 to 8/18, 1950, that I last saw the deceased alive on August 16, 1950, and that death occurred at 2 p. m., from the causes and on the date stated above.

23A. SIGNATURE Mary M. Clift

23B. ADDRESS Maryland General Hospital 23C. DATE SIGNED Aug. 18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE Aug 22/50

24C. NAME OF CEMETERY OR CREMATORY Balds Cem

24D. LOCATION (City, town, or county) (State) Balds

DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1950

REGISTRAR'S SIGNATURE Dr. J. Williams

25. FUNERAL DIRECTOR William T. Hume

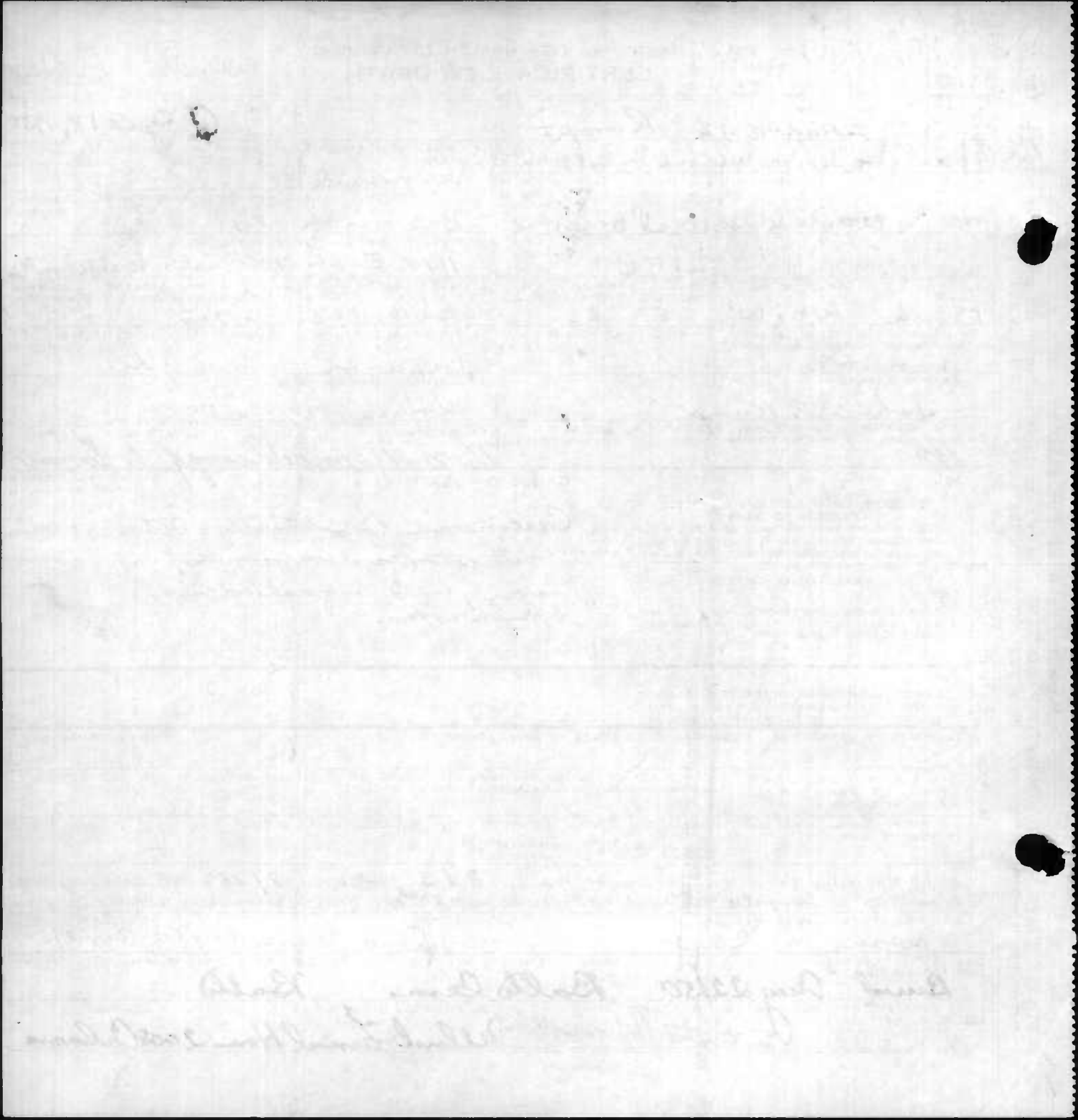
ADDRESS 2008 Chelan

VS 150

46 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 7241**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bertha Gordon

2. DATE OF DEATH

Aug. 19-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *2406 E. Hoffman St.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE *Md.*
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
Baltimore 8-03

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2406 E. Hoffman St.

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 26, 1895

9. AGE (In years, last birthday)

55

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John M. Teudel

14. MOTHER'S MAIDEN NAME

Fannie B. Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, so or unknown) (If yes, give war or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

George E. Gordon

18.

170X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

Carcinoma, metastatic, general

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma, rt breast

3-3 1/2 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *16 March, 1950*, to *19 Aug*, 19*50*, that I last saw the deceased alive on *15 Aug*, 19*50*, and that death occurred at *11:30* m., from the causes and on the date stated above.

23A. SIGNATURE

Howard J. Miller

23B. ADDRESS

1513 N. Mt. Vernon Ave

23C. DATE SIGNED

21 Aug 50

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 23-1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 22 1950

REGISTRAR'S SIGNATURE

Wm. Goodman

25. FUNERAL DIRECTOR

ADDRESS

John C. Miller, Inc. 2435 E. Oliver St

VS 150

Wm. Goodman

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LETTER

CONFIDENTIAL

SECRET

TOP SECRET

NOFORN

NOFORN

NOFORN

NOFORN

NOFORN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Donahue

2. DATE

OF
DEATH

Aug. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

2907 W. North Ave.,

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2907 W. North Ave.,

c. Length of stay in Baltimore

18--

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 19, 1893

9. AGE (In years last birthday)

57

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tabulator Operation

10B. KIND OF BUSINESS OR INDUSTRY

State of Md.

11. BIRTHPLACE (State or foreign country)

Massachusetts

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Donahue

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Betty Donahue 2907 W. North Ave.,

18.

4/20.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis (Sudden)

15 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Cardiovascular disease
Bronchitis & Asthma & Bronchitis

8 yrs.

8 yrs.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 12, 1950, to Aug 19, 1950, that I last saw the deceased alive on Aug 10, 1950, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8-23-1950

Woodlawn

Woodlawn

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 22 1950

Walter Williams, M.D.

G. Howard Strong 3207 W. North Ave.

VS 150

34192

937

Dr. Earle X. Thomas

1202 St. Paul St.

3202 Love Luster Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7243

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mrs. Bessie Stone

2. DATE
OF
DEATH

8/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

14-02

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Hospital for the Women of Md.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

309 McMechan St

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7-21-1916

9. AGE (In years last birthday)

34

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hwpf

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Perry Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Wm. Clark Brewer

14. MOTHER'S MAIDEN NAME

Margaret Young

S.B. 26610

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-22-8895

17. INFORMANT

Mrs. Bessie Stone 309 McMechan St

ADDRESS

18.

670X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)Multiple amniotic particulate emboli of lung
(A) Pulmonary embolism and kidney
premature separation of the placenta

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

pelvic thrombosis

DUE TO

(C) Intestinal Infection

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Secondary purplish vascular collapse

INTERVAL BETWEEN ONSET AND DEATH

8 hours

12 hours

12 hours

over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/18, 1950, to 8/21, 1950, that I last saw the deceased alive on 8/21, 1950, and that death occurred at 12:41 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Looni D. Poca

M.D.

23B. ADDRESS

Women's Hospital of Maryland

23C. DATE SIGNED

8/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-24-50

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county)

BALTIMORE MD.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Lutington Williams, M.D.

25. FUNERAL DIRECTOR

Charles H. Evans & Son Inc

ADDRESS

118 W. Mt. Royal Ave 146B

AUG 22 1950

VS 150

See Document File 50-7423

8-28-51 E.S.

Stillbirth # 36610 - 8/20/50.

50 7244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7244

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Irvin Simmons

2. DATE
OF
DEATH

8/19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

City

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

2712 Berea Road

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 25-32

D. STREET ADDRESS (If rural, give location)

2712 Berea Road

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 23, 1905

9. AGE (In years,

last birthday)

44 yrs.

10. Under 1 Year

Days

18 19

11. Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Presser

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Hill, VA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Eugenia Lambert

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

220-059-737

17. INFORMANT

ADDRESS

Mrs Emma Simmons 2712 Berea Rd.

18.

162X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchogenic Carcinoma

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Bronchial Hemorrhage

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 15, 1950, to Aug. 19, 1950, that I last saw the
deceased alive on Aug. 19, 1950, and that death occurred at 1:45 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Jerry S. Luck

M. D.

23B. ADDRESS

427 Swale Ave

23C. DATE SIGNED

8/19/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Aug. 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Abraham Mem. Pk.

24D. LOCATION (City, town, or county)

Baltimore Co. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Walter Funeral Home
1631 David Hill Ave.

AUG 22 1950

VS 150

6904Y 43

47C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 7245

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bertha Jenkins

2. DATE
OF
DEATH

August 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore City

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

3031 Hudson St.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

1-01

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3031 Hudson St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec 12 1894

9. AGE (In years last birthday)

56

If Under 1 Year

7 Months 8 Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Clifford Green

14. MOTHER'S M maiden NAME

Laura Crisp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Milton Jenkins 3031 Hudson St.

ADDRESS

18. 170 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of left mammary gland

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

over 1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Secondary anemia. Essential hypertension. Chronic mitral regurgitation

over 6 mon

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-10-1950, to Aug. 18, 1950, that I last saw the deceased alive on Aug. 18, 1950, and that death occurred at 7:10 p. m., from the causes and on the date stated above.

23A. SIGNATURE

J. B. Monahan, M.D.

23B. ADDRESS

3037 O'Donnell St.

23C. DATE SIGNED

8-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 22 1950

24C. NAME OF CEMETERY OR CREMATORY

Mount Carmel

24D. LOCATION (City, town, or county)

O'Donnell St.

(State)

MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wendell J. Shippel 315 S Highland

ADDRESS

AUG 22 1950

VS 150

50

Best of 6

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

J-525
50 7246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7246

BIRTH NO.

| | | | | | |
|---|---------------------------------|--|---|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Bertha Johnson</i> | | | 2. DATE OF DEATH <i>Aug 19, 1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>601 4. mdd</i> | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | O. STREET ADDRESS (If rural, give location) <i>1528 E. Preston St</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>8-20-92</i> | | 9. AGE (In years last birthday) <i>57</i> Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Texas</i> |
| 13. FATHER'S NAME <i>James B. Nichols</i> | | | 14. MOTHER'S MAIDEN NAME <i>Edda Richardson</i> ✓ | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS |

| | | | | | | |
|--|--|---|--|--|------------------|---|
| 18. <i>416X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH (A) <i>Pulmonary embolism</i> DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (B) <i>Acute Fibrosclerosis</i> DUE TO <i>Rheumatic heart disease, mitral</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) <i>? SBE or Pyelonephritis</i> | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from <i>8-1-</i> , 19 <i>50</i> to <i>8-19-</i> , 19 <i>50</i> that I last saw the deceased alive on <i>8-19-</i> , 19 <i>50</i> and that death occurred at <i>12:15 Pm.</i> , from the causes and on the date stated above. | | | | | | |
| 23A. SIGNATURE <i>Thomas J. Walsh</i> M. D. | | | 23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i> | | 23C. DATE SIGNED | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE <i>Aug 23/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus M. Park</i> | | |
| 24D. LOCATION (City, town, or county) (State) <i>Arbutus Md</i> | | DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 22 1950</i> | | REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i> | | |
| 25. FUNERAL DIRECTOR <i>Mrs. G. H. Q. Elliott & Daughter</i> | | ADDRESS <i>1129 N. Caroline St. 95B</i> | | | | |

VS 150

7208A

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-635
50 7247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7247

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THEODA M. BORTNER

2. DATE
OF
DEATH

Aug. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3508 Clifftmont Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3508 Clifftmont Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 5, 1868

9. AGE (In years last birthday)

82

10 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Michael Smith

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mrs. Theoda Hissey - 3508 Clifftmont Ave.

18. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

?

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, 1950, that I last saw the deceased alive on Aug 20, 1950 and that death occurred at 9:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 22 1950

Livingston Williams, M.D.

H.M. J. Lickner & Sons

Balto

VS 150

937 Md.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7248

Registered No. _____

BIRTH NO. _____

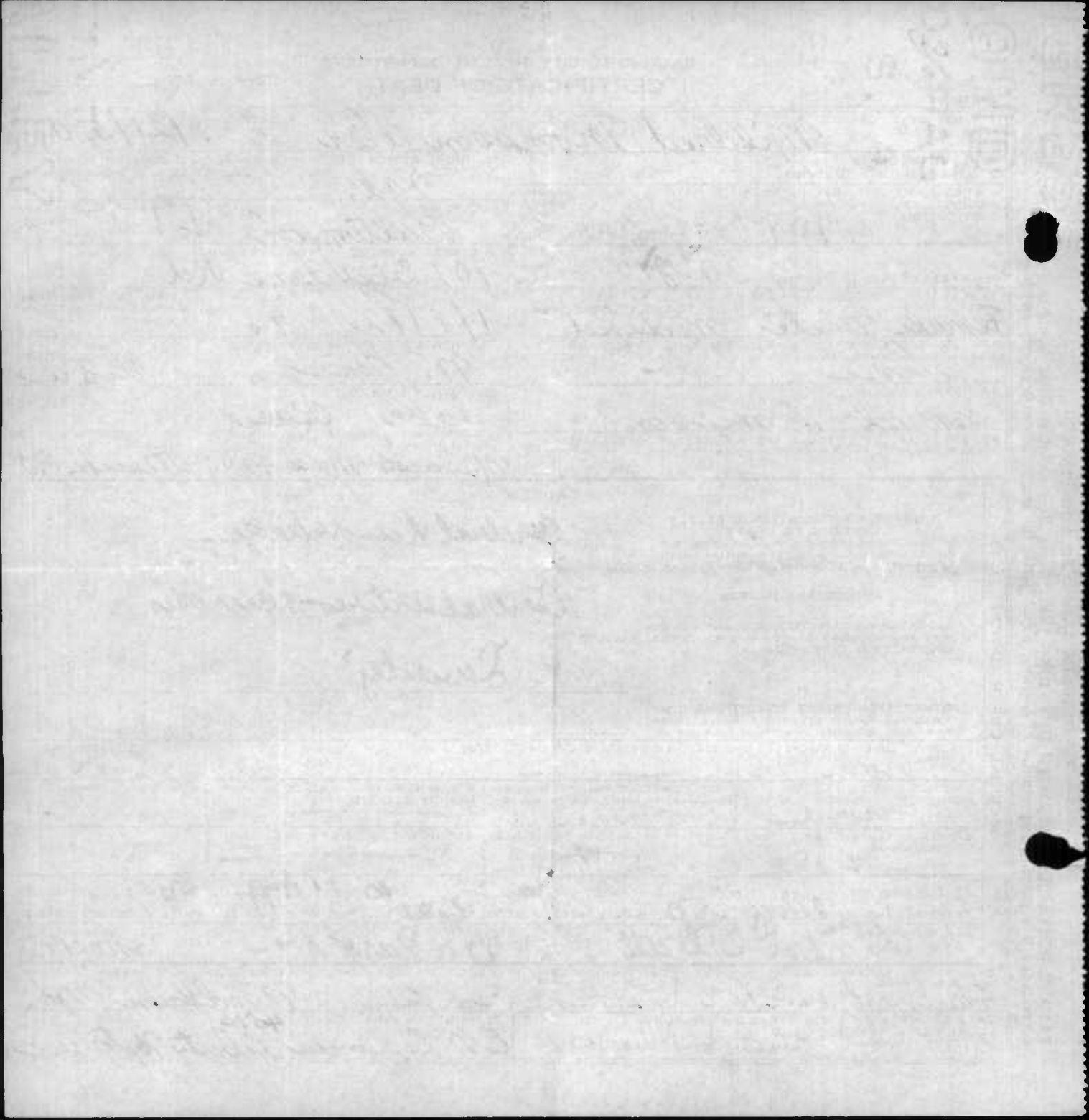
| | | | |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Mildred Thompson Aler</i> | | 2. DATE OF DEATH <i>8/21/50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____ | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>707 Deepdene Rd</i> | | C. CITY OR TOWN (If outside corporate limits, write TOWNSHIP and give township) <i>Baltimore</i> | |
| c. Length of stay in Baltimore <i>30 yrs</i> | | D. STREET ADDRESS (If rural, give location) <i>707 Deepdene Rd</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>1/8/72</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>—</i> | 9. AGE (In years last birthday) <i>78</i> |
| 13. FATHER'S NAME <i>Samuel Thompson</i> | | 11. BIRTHPLACE (State or foreign country) <i>W. Va</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 16. SOCIAL SECURITY NO. <i>none</i> | | 14. MOTHER'S MAIDEN NAME <i>Sally Reed</i> | |
| 17. INFORMANT <i>Mr Jacob Moss</i> | | ADDRESS <i>4405 Atwood Rd</i> | |

| | | | |
|--|--|--|----------------------------------|
| 18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH <i>Cerebral hemorrhage</i> | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) <i>Cerebral Arterio-sclerosis</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) <i>Senility</i> | |

| | | | | | |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <i>none</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>none</i> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>none</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>none</i> | | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>Jan 2</i> , 19 <i>30</i> , to <i>21 Aug</i> , 19 <i>50</i> that I last saw the deceased alive on <i>2 Aug</i> , 19 <i>50</i> and that death occurred at <i>6:30 p.m.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Walter S. Stratt</i> | | 23B. ADDRESS <i>712 Park Ave</i> | | 23C. DATE SIGNED <i>22 Aug 1950</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombment</i> | | 24B. DATE <i>8/23/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Woodlawn Md.</i> | | 25. FUNERAL DIRECTOR <i>E. W. Lamoreaux</i> | | | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 22 1950</i> | | REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | | ADDRESS <i>4510 Liberty St Ave</i> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 7249

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

VERTIE V. WILKINSON

2. DATE
OF
DEATH

8-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

Sinai Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

28-31

D. STREET ADDRESS (If rural, give location)

3837 Beehler Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE--MARRIED.

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 17, 1882

9. AGE (In years
last birthday)

67 yrs

11 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

York, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John Senft

14. MOTHER'S MAIDEN NAME

Emma Cell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Jane Farino, 3837 Beehler Ave.

18.

203X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from 8-10, 1950 to 8-20, 1950, that I last saw the
deceased alive on 8-20, 1950, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry C. Steffman

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8-20-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 22 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

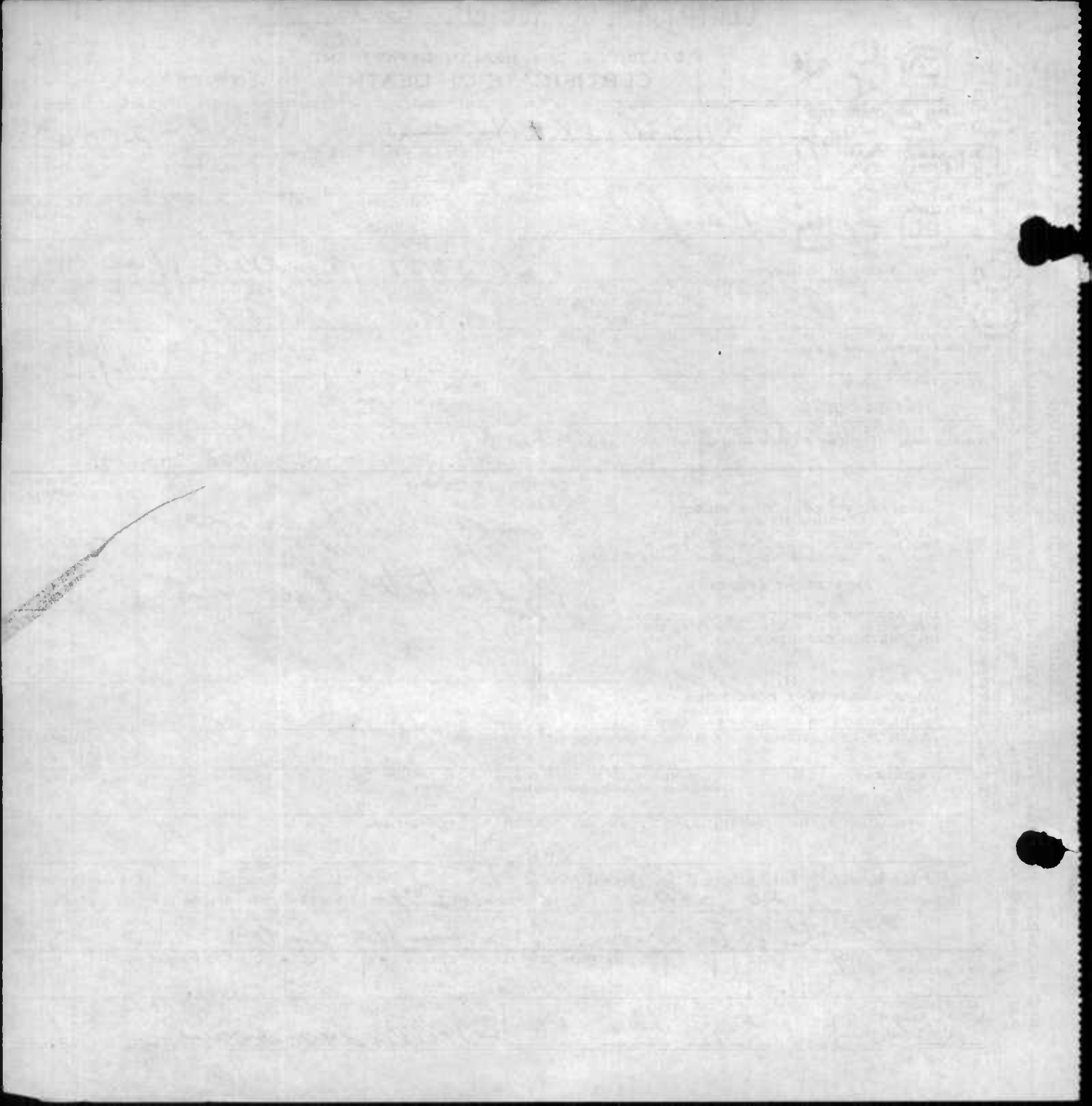
E. Willis Lamoreaux

ADDRESS

4510 Liberty
Heights Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7250

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KATHERINE L. DUPONT

2. DATE
OF
DEATH

August 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2104 Boone Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Jan. 24, 1905

9. AGE (In years
last birthday)

45

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Alexander Barnett

14. MOTHER'S MAIDEN NAME

Mary Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Dolores Dupont, 2104 Boone St., Balto.

18. 322.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Chronic alcoholism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

(B) Bronchopneumonia

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☒

M.D.

MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

August 21, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill Cemetery

24D. LOCATION (City, town, or county)

Towson, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 22 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John Burns' Sons, Towson, Maryland

VS 151

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Which of these ^{two} apparently
unrelated conditions
was mainly responsible
for the death?

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7251

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ELIZABETH M. HEVERN

2. DATE
OF
DEATH

August 19, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland **3901 Hudson St.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3901 Hudson St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 9, 1863

9. AGE (In years last birthday)

87

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

House Work.

11. BIRTHPLACE (State or foreign country)

New Cumberland, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Cook

14. MOTHER'S MAIDEN NAME

Catherine Danner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

John W. Hevern 511 E. 22nd St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **Arteriosclerotic cardiovascular disease**

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6/19, 1949** to **8/19, 1950**, that I last saw the deceased alive on **8/19, 1950** and that death occurred at **10:00 P.M.** on the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

8/23/50

Mt. Olivet Cemetery

New Cumberland, Pa.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 22 1950

William M. Williams, M.D.

Charles S. Zeile

901 S. Conkling St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. The first part of the report is a general description of the project and its objectives. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

2. The second part of the report is a detailed description of the methodology used in the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

3. The third part of the report is a detailed description of the results of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

4. The fourth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

5. The fifth part of the report is a detailed description of the recommendations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

6. The sixth part of the report is a detailed description of the references used in the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7252

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JESSIE SHELTON

2. DATE
OF
DEATH

8-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Johns Hopkins Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give
township)

Baltimore

9-09

C. Length of stay in Baltimore

5 yrs

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1820 Annapolis St

5. SEX

M.

6. COLOR OR RACE

C.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

7-10-1929

9. AGE (In years
last birthday)

21

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Trucker

10B. KIND OF BUSINESS OR
INDUSTRY

Container Corp. of America, S.C.

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Shelton

14. MOTHER'S MAIDEN NAME

Ruby Belle Bowser

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

248-346328

17. INFORMANT

ADDRESS

Ruby Belle Shelton - Leeds, S.C.

18. E 981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) INTERNAL HEMORRHAGE

DUE TO BULLET WOUNDS OF BACK

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)
Street21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Caroline Street & Ashland Avenue

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
August 19, 1950 11:40P.21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☒
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

Stanley H. Dineen

M.D.

23B. CHIEF MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Aug 20, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Chester, S.C.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

AUG 22 1950

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph S. Dicks, Jr. 1304 N. Central

VS 151

N-86914

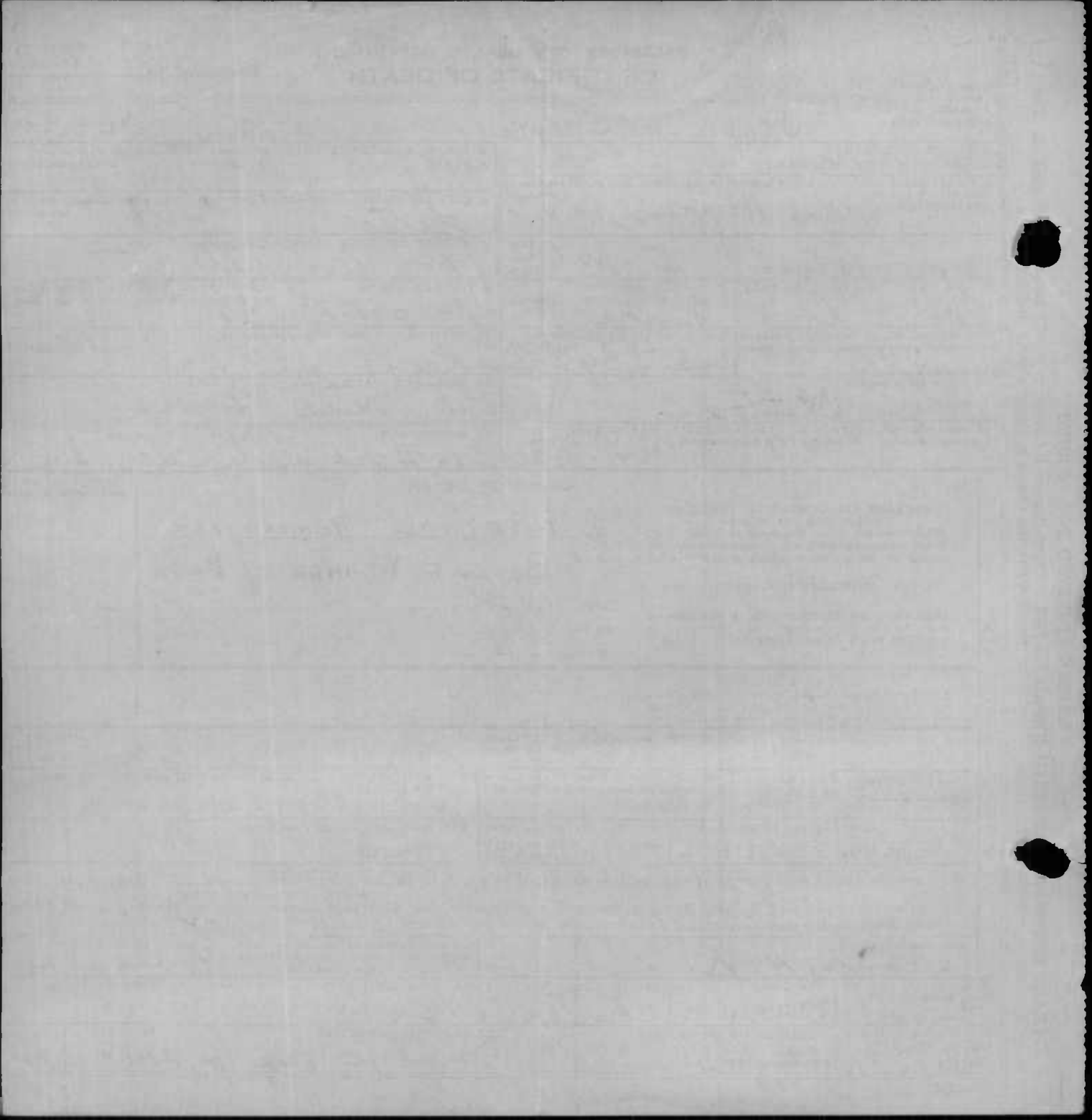
9704K

166

Vale

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7253

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) *Michael A. Harris* 2. DATE OF DEATH *Aug 21, 1950*

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE *Maryland* B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
619 N Bentall St. Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
16-05

D. STREET ADDRESS (If rural, give location)
619 N Bentall St
c. Length of stay in Baltimore
Yrs. _____ Mos. _____ Days _____

5. SEX *Male* 6. COLOR OR RACE *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Married* 8. DATE OF BIRTH *July 27, 1884* 9. AGE (in years last birthday) *66* 10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Mail Clerk* 10B. KIND OF BUSINESS OR INDUSTRY *A Sabel Co* 11. BIRTHPLACE (State or foreign country) *Baltimore Md* 12. CITIZEN OF WHAT COUNTRY? _____

13. FATHER'S NAME *Unknown* 14. MOTHER'S MAIDEN NAME *Rebecca (Unknown)*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) *No* (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. *213-03-2434* 17. INFORMANT *Charles J. Harris, 3402 Yorkway* ADDRESS _____

18. *331X* CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
(A) *Cerebral Hemorrhage*
DUE TO
ANTECEDENT CAUSES
(B) *Hypertension*
DUE TO
(C) _____

INTERVAL BETWEEN ONSET AND DEATH
20 hrs.
years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II
19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDER- LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ 21E. INJURY OCCURRED WHILE AT ☐ WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from *Aug 1*, 19*48* to *Aug 21*, 19*50* that I last saw the deceased alive on *Aug 21*, 19*50*, and that death occurred at *6 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE *J Mendelis* 23B. ADDRESS *651 N Bentall St* 23C. DATE SIGNED *8/21/50*

24A. BURIAL, CREMA- TION, REMOVAL (Specify) *Burial* 24B. DATE *8/24/50* 24C. NAME OF CEMETERY OR CREMATORY *U. S. National* 24D. LOCATION (City, town, or county) (State) *Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR *AUG 22 1950* REGISTRAR'S SIGNATURE *Winifred Williams, M.D.* 25. FUNERAL DIRECTOR *Wm. Cook, Inc.* ADDRESS *1217 St. Paul St.*

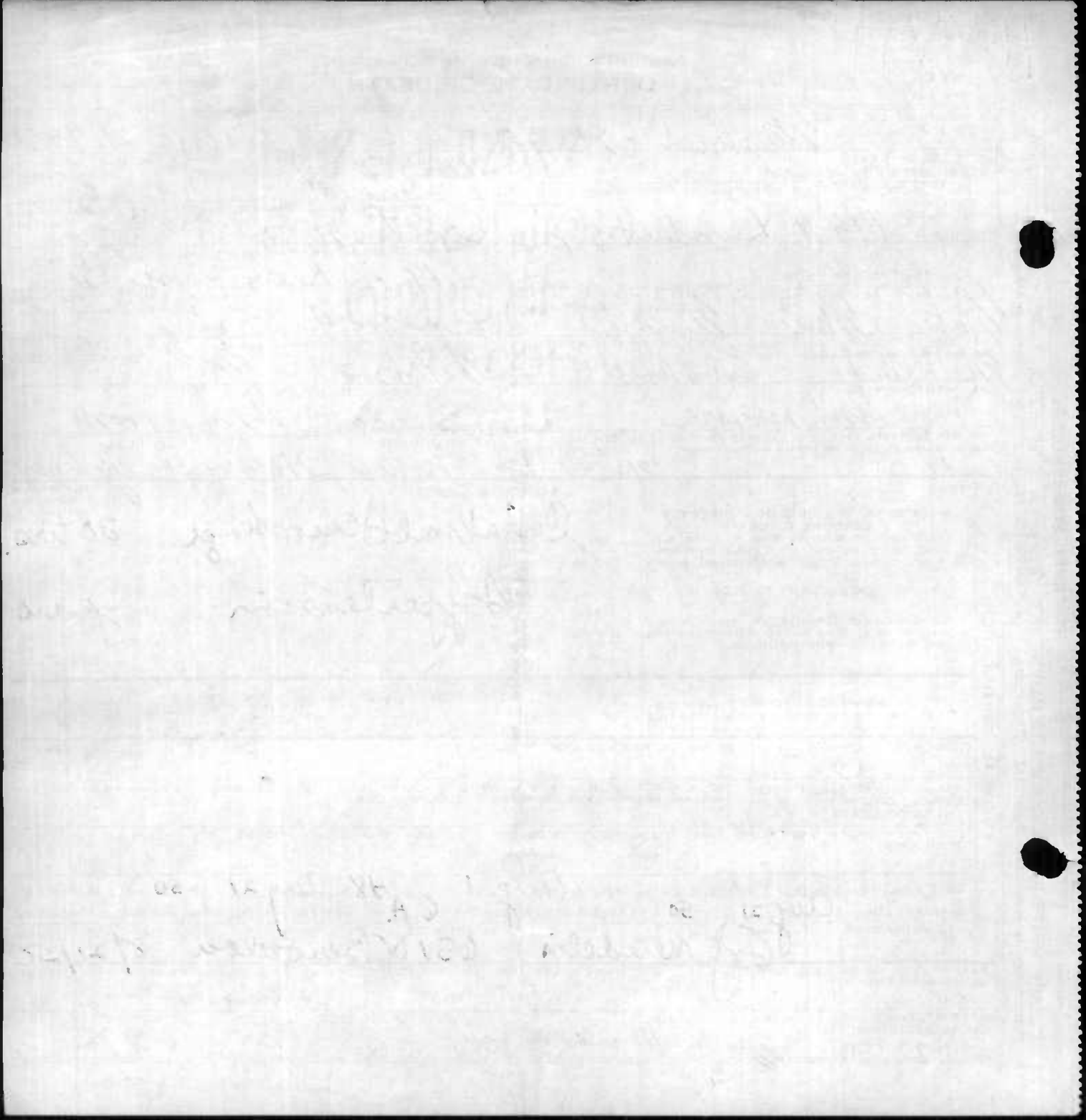
VS 150

39060

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7254

| | | | | | |
|--|--|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) LENA CRAUER | | 2. DATE OF DEATH Aug. 20, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 19-04 | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 114 S. Addison St. | | D. STREET ADDRESS (If rural, give location) 114 S. Addison St. | | E. Yrs. Mos. Days 8 yrs | |
| c. Length of stay in Baltimore | 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW | 8. DATE OF BIRTH MAY 15, 1863 | 9. AGE (In years last birthday) 87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 17. INFORMANT ADDRESS Mrs. Kulkoski 114 S. Addison St. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. NONE | | 18. CAUSE OF DEATH 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral accident (Thrombosis) Several times DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Generalized Arteriosclerosis OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Many years | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:10 P.M. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Abram Goldman M.D. | | 23B. ADDRESS 206 S. Gilman St. | | 23C. DATE SIGNED 8/21/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE Aug. 23, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY LONDON PARK BALTIMORE, Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1950 | | REGISTRAR'S SIGNATURE Wilmington Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS George L. Schwab 2101 Frederick Ave. | |

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

RECEIVED
JAN 10 1900
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

IN SENATE,
JANUARY 10, 1900.

REPORT
OF THE
ATTORNEY GENERAL,
JAMES C. CLARK,
FOR THE YEAR
1899.

ALBANY:
J. B. LEECH, PRINTERS,
1899.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Estelle Ollie Jones

2. DATE
OF
DEATH

8-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1320 Harlem Avenue (17)

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

June 23, 1924

9. AGE (in years
last birthday)

26

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Moses

14. MOTHER'S MAIDEN NAME

Marie Burk

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
none

17. INFORMANT

ADDRESS 4940

Records* Balto City Hospitals Eastern Ave.

18. 002X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary Tuberculosis

3 weeks ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-19, 1950, to 8-21, 1950, that I last saw the
deceased alive on 8-21, 1950, and that death occurred at 7:25 A.M. from the causes and on the date stated above.

23A. SIGNATURE

J. J. Hogan

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-21-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Kelson 1303 Presston St.

Geo. G. Kelson 1303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7256

BIRTH NO. _____

| | | | | | |
|---|------------------------------|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) Charles Holman | | | 2. DATE OF DEATH August 20, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 1732 Presstman St. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION _____ | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 15-02 | | |
| c. Length of stay in Baltimore ? Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) 1723 Presstman St. | | |
| 5. SEX M | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W | B. DATE OF BIRTH 1882 | 9. AGE (In years last birthday) 68 | If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY unknown | 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. 213-14-3266 | 17. INFORMANT ADDRESS Elizabeth Johnson 1709 Presstman St. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO Hypertension ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Senility | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | |
| 19A. DATE OF OPERATION _____ | | | 19B. MAJOR FINDINGS OF OPERATION _____ | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____ | | |
| 22. I hereby certify that I attended the deceased from 4/20 , 19 50 , to 8/20 , 19 50 , that I last saw the deceased alive on 8/10 , 19 50 , and that death occurred at 10:00 m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Ralph W. Neukirch | | M. D. _____ | 23B. ADDRESS 44 N. Oglethorpe | | 23C. DATE SIGNED 8/22/50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/24/50 | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn | 24D. LOCATION (City, town, or county) (State) Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1950 | | REGISTRAR'S SIGNATURE Washington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS Geo. G. Kelson 1303 Presstman St. | | |

426

Bilmore of

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7257

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELTON TAYLOR

2. DATE
OF
DEATH

Aug 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Thayer 2

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
PENNA.B. COUNTY
V-35B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

WYALUSING

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

4-12-10

9. AGE (in years
last birthday)

40

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR
INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Elisha Taylor

14. MOTHER'S MAIDEN NAME

Bernie Burgess

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.17. INFORMANT
ADDRESS

JOHNS HOPKINS HOSPITAL

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Acute yellow atrophy of
liver due to unknown
causeINTERVAL BETWEEN
ONSET AND DEATH

1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Epilepsy, idiopathic

26 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-18 1950 to 8-22 1950, that I last saw the
deceased alive on 8-22 1950 and that death occurred at 5:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Robomani

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-25-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

CAMP TOWN
Campdown - Pa.DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

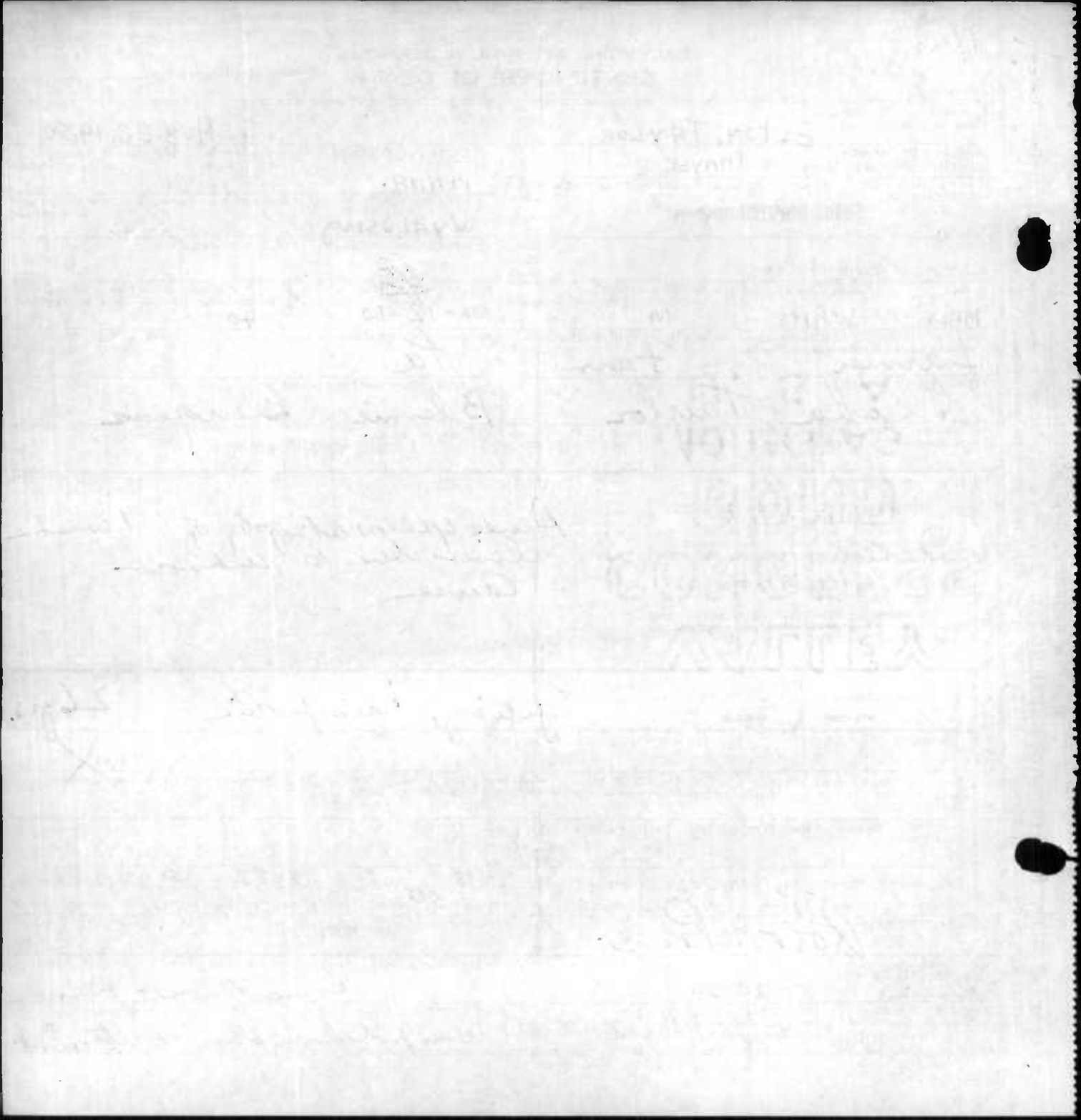
ADDRESS

Wm. J. Tichner & Son - Balto., Md.

VS 150

10010

125a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7258
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles W. Berger

2. DATE
OF
DEATH

Aug. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Balto. Md.*

4. USUAL RESIDENCE (Where deceased lived, Institution: residence before admission)

A. STATE *Maryland*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or location)

38 University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 23-02

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1621 Patapsco St. Balto. 30

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

Dec. 28, 1901

9. AGE (In years last birthday)

48 49 yrs

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stevadore

10B. KIND OF BUSINESS OR INDUSTRY

Jarka Corp.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm. Charles Berger

14. MOTHER'S MAIDEN NAME

Mary Emma Steinbach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

yes 1920 to 1923 Navy

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Edna Berger-wife 1621 Patapsco

18. *340.3*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Lower nephron nephrosis*

8/19 - 8/21

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Arachnoiditis*

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Obesity

19A. DATE OF OPERATION

8/17/50

19B. MAJOR FINDINGS OF OPERATION

Arachnoiditis

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug. 15, 1950* to *Aug. 21, 1950*, that I last saw the deceased alive on *Aug. 21, 1950* and that death occurred at *10:00 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

Raymond Bradshaw, Jr.

23B. ADDRESS

M. D. University Hospital, Balto. Md.

23C. DATE SIGNED

Aug. 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 24/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross Cemetery

24D. LOCATION (City, town, or county)

Ritchie Highway Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 22 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

KRAUSE FUNERAL HOME 1216 S. Charles

ADDRESS

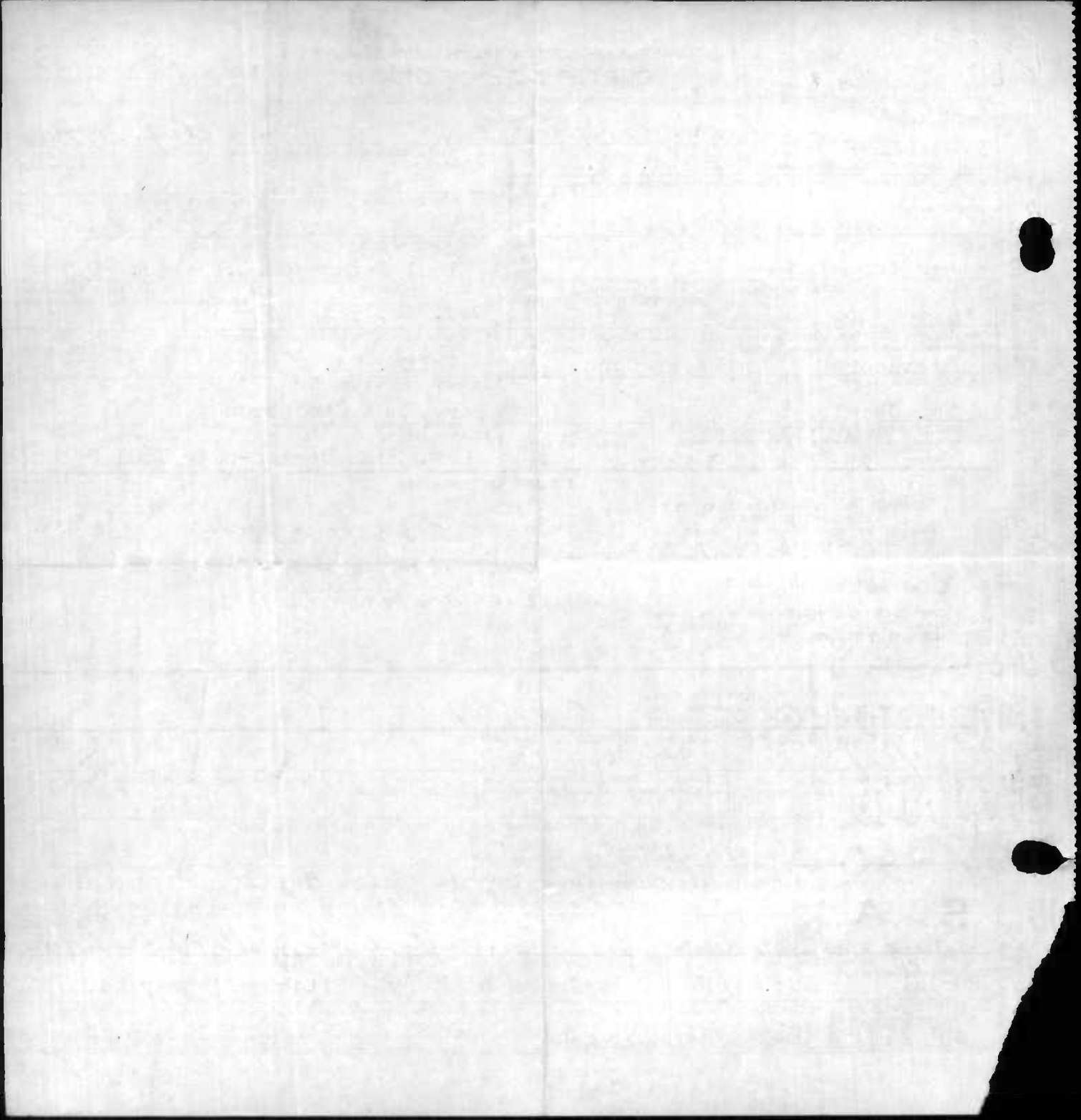
VS 150

940 55

81a Balto 30 Md.

MARGIN RESERVED FOR BINDING

WRITE IN INK. Every item of information should be fully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7259

530
50 7259
BIRTH NO.

| | | | |
|---|-------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) JAMES M. DONNET | | 2. DATE OF DEATH <u>Aug 20, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Est 6, Med</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside corporate limits, write full name, and give township) <u>Baltimore 8-05</u> | |
| c. Length of stay in Baltimore <u>67 yrs</u> Yrs. <u>67</u> Mos. <u>0</u> Days <u>0</u> | | D. STREET ADDRESS (If rural, give location) <u>1831 Rutland Ave</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 6 - 1882</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>paving insp.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>City of Balto.</u> | 9. AGE (in years last birthday) <u>68</u> If Under 1 Year: Months <u>0</u> Days <u>0</u> If Under 24 Hours: Hours <u>0</u> Min. <u>0</u> |
| 13. FATHER'S NAME <u>John Donnet</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Anderson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Mexican War</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |

| | | |
|---|--|--|
| 18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> | CAUSE OF DEATH <u>Myocardial Infarction</u> | INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Coronary Occlusion</u> | (B) <u>Coronary Occlusion</u> | <u>36 hr</u> |
| | (C) <u>Coronary Arteriosclerosis</u> | <u>10-20 yrs</u> |
| II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. | | |

| | | | | | |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <u>8-20-50</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>8-20-</u> , 19 <u>50</u> , to <u>8-20-</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>8-20-</u> , 19 <u>50</u> , and that death occurred at <u>2P</u> m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>David Dickens</u> | | 23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | | 23C. DATE SIGNED <u>8-21-50</u> | |
| 24A. BURIAL, CREMA- TION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>8/23/50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u> | | 24E. STATE <u>Md.</u> | | 25. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 22 1950</u> | | REGISTRAR'S SIGNATURE <u>Washington Williams, M.D.</u> | | ADDRESS <u>BALTO., -13, MD.</u> | |

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7260

BIRTH NO. 50 7260

1. NAME OF DECEASED
(Type or Print)

Walter R. Roberts

2. DATE
OF
DEATH

Aug. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2241 E. Biddle Street

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Metcy Hospital (DCA)

C. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

June 3, 1884

9. AGE (In years last birthday)

66

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Civil Service

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Fed. Gov't.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Newton Roberts

14. MOTHER'S MAIDEN NAME

Minnie May Rees

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT 2241 E. Biddle Street

Mrs. Margaret C. Roberts

18.

420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, Jr.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

Aug. 20, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 22 1950

REGISTRAR'S SIGNATURE

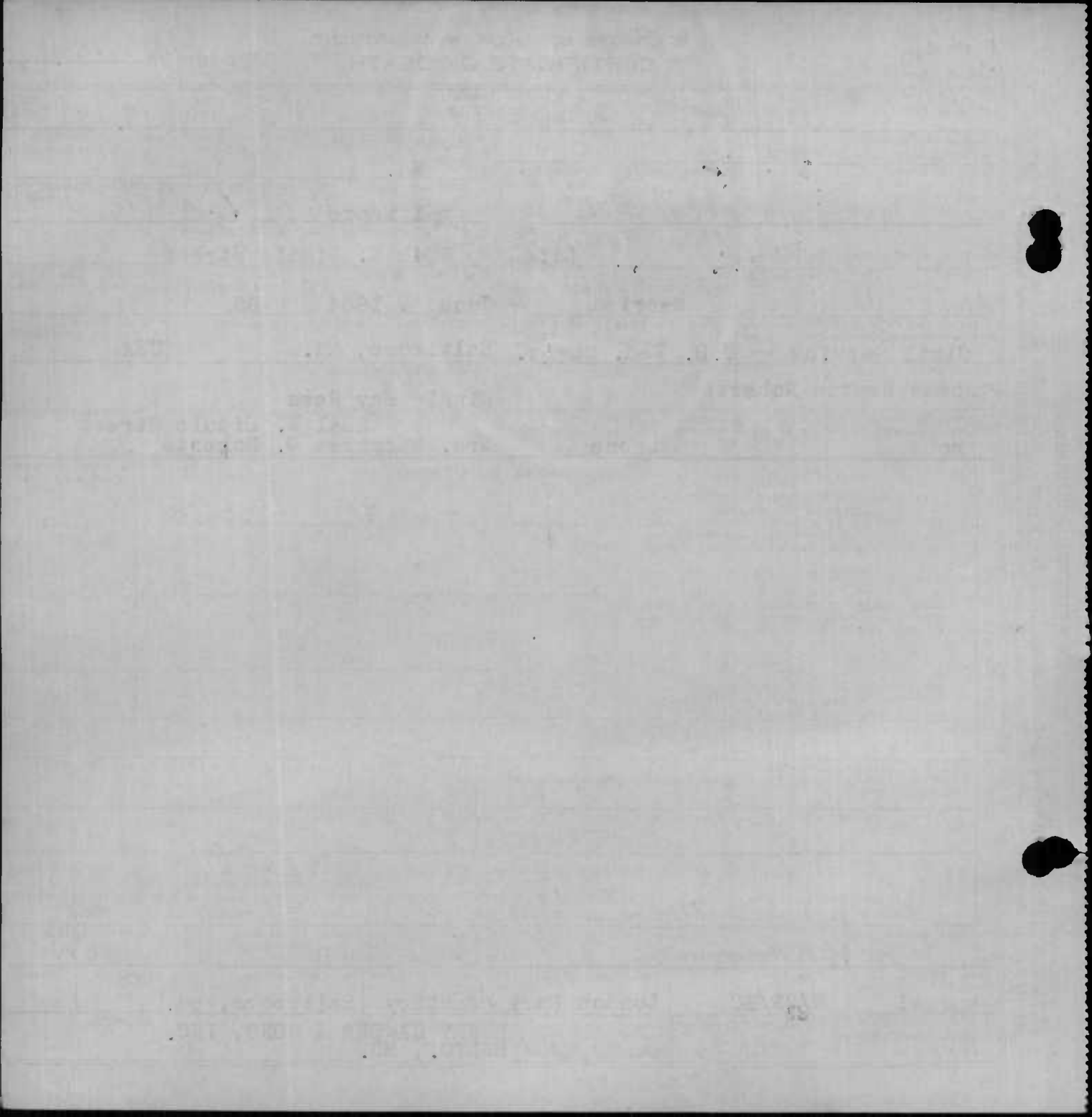
William Williams, Jr.

125 FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.

BALTO., MD.

ADDRESS



PLEASE WRITE PRECISELY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Isabel J. Miller

2. DATE
OF
DEATH

Aug 21/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4417 Kathlamet Ave

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 28-03

c. Length of stay in Baltimore

31 Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

4417 Kathlamet Ave

5. SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan 1/1884

9. AGE (In years last birthday)

66

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Boston Mass.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Patrick P. Hennessy

14. MOTHER'S MAIDEN NAME

Alice Jane Ross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Ruth J. Miller 4417 Kathlamet Ave

18.

420.1 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Thrombosis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Arteriosclerosis

10 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb 2 - 1950, to July 18, 1950, that I last saw the deceased alive on July 18, 1950, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Isaac C. Dickson

M. D.

23B. ADDRESS

3055 W. North Ave

23C. DATE SIGNED

Aug 21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF GEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Aug 24/1950

Woodlawn

Woodlawn

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

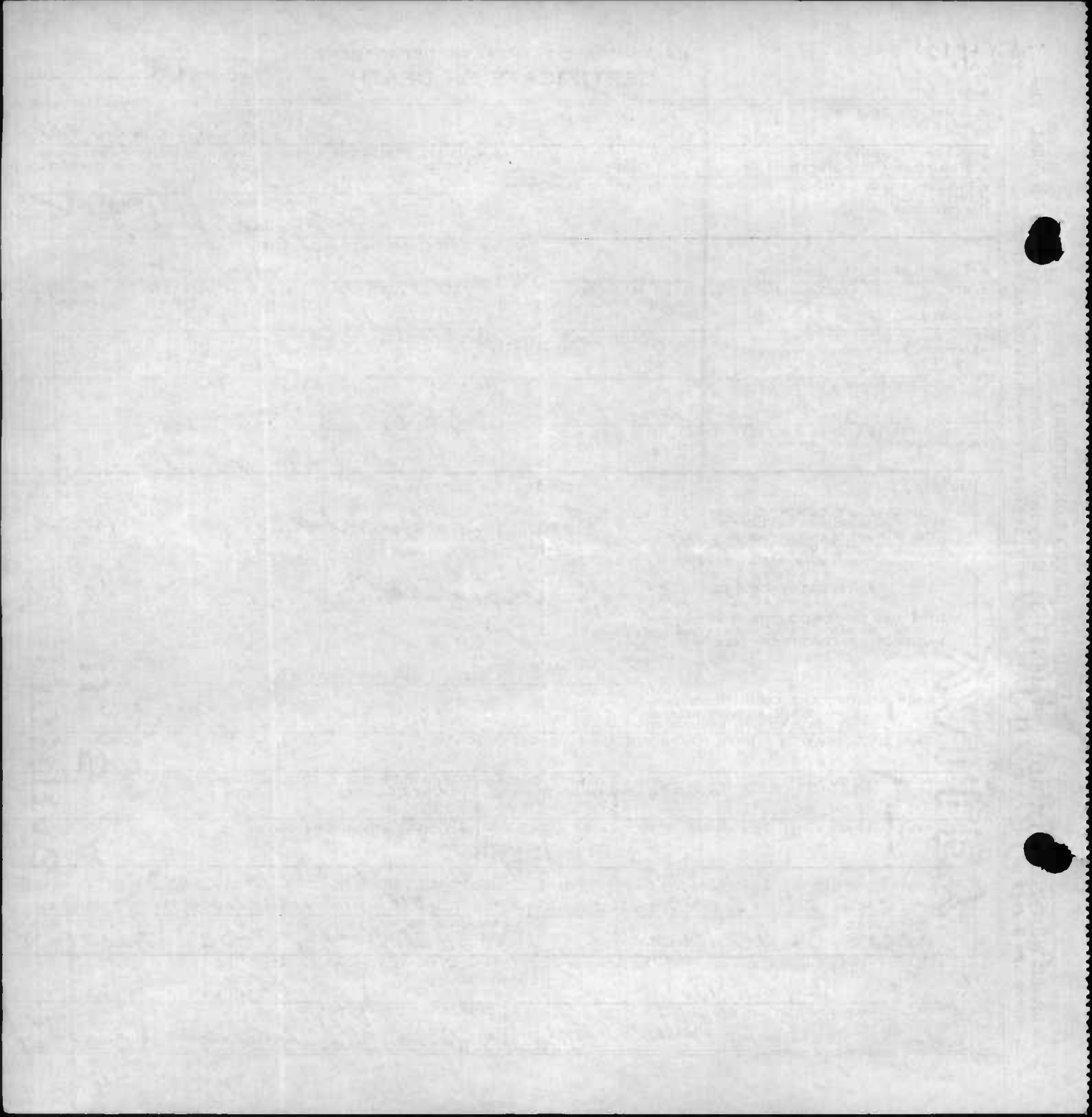
William Williams, M.D.

Harry Williams 4204 Redwood Ave

AUG 22 1950

VS 150

94a



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7262

BIRTH NO. 50 7262

| | | | | | |
|--|------------------------------|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) William H. Dutton | | | 2. DATE OF DEATH Aug 19, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) 532 N. Carrollton Ave | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-02 | | |
| C. Length of stay in Baltimore Life | | | D. STREET ADDRESS (If rural, give location) 532 N. Carrollton Ave. | | |
| 5. SEX Male | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH May 28, 1895 | 9. AGE (In years last birthday) 55 | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Chauffeur Dept. Store | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | |
| 13. FATHER'S NAME William H. Dutton | | | 14. MOTHER'S MAIDEN NAME Jane ? | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Berna Dutton | | | ADDRESS 532 N. Carrollton Ave | | |
| 18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebro-Vascular Accident DUE TO Hypertension DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH Cerebro-Vascular Accident Hypertension II | | |
| 19A. DATE OF OPERATION 0 | | | 19B. MAJOR FINDINGS OF OPERATION | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 1948 , 19, to 8/19 , 19 50 , that I last saw the deceased alive on 8/18 , 19 50 , and that death occurred at 7:30 A. M., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE J. Preston Grant | | M. D. 661 N. Carrollton | | 23C. DATE SIGNED 8/21/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-23-1950 | | 24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25. FUNERAL DIRECTOR Mrs. Katie R. Williams | | ADDRESS 322 N. Schroeder St | |
| DATE RECEIVED BY LOCAL REGISTRAR Aug 24 1950 | | REGISTRAR'S SIGNATURE William H. Dutton | | | |

CLYDE W. BATES

William H. Bates

1875

1875

1875

1875

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1875

1875

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1875

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7263
Registered No. _____

BIRTH NO. _____

| | | | |
|---|------------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) Caroline S. Young Hawkins, | | 2. DATE OF DEATH Aug. 20, 1950. | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 303 N. Arlington Ave | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-02 | |
| C. Length of stay in Baltimore Life Yrs. _____ Mos. _____ Days _____ | | D. STREET ADDRESS (If rural, give location) 303 N. Arlington Ave, | |
| 5. SEX Female | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Feb. 22, 1876 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 74 If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____ |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Dennis Young | | 14. MOTHER'S MAIDEN NAME Cecelia | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Drucilla Johns | | ADDRESS 303 N. Arlington Ave | |

| | |
|---|---|
| 18. 170X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ca of Breast (A) _____ DUE TO _____ ANTECEDENT CAUSES (B) _____ DUE TO _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH 8 mos. |
|---|---|

| | | |
|---|---|--|
| 19A. DATE OF OPERATION 0 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **8-15**, 19**50**, to **8-20**, 19**50**, that I last saw the deceased alive on **8-19**, 19**50**, and that death occurred at **3:30 A.M.**, from the causes and on the date stated above.

| | | |
|--|--|------------------------------------|
| 23A. SIGNATURE W. McDonald Bando | 23B. ADDRESS 2445 Druid Hill Ave | 23C. DATE SIGNED 8-21-50 |
|--|--|------------------------------------|

| | | | |
|--|-------------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-24-1950 | 24C. NAME OF CEMETERY OR CREMATORY W. Auburn Cem. | 24D. LOCATION (City, town, or county) (State) Balto Md |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1950 | | REGISTRAR'S SIGNATURE W. McDonald Bando | 25. FUNERAL DIRECTOR Mrs. Katie R. Williams |
| | | ADDRESS Schroeder St | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1950-51

1950-51

1950-51

1950-51

1950-51

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1950-51

V-536
50 7264
Y. 47305

VANDERFORD
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7264

| | | | | | |
|---|------------------------------|---|--|--|---|
| BIRTH NO. <u>Y. 47305</u> | | 1. NAME OF DECEASED (Type or Print) <u>Andrey Vanderford</u> | | 2. DATE OF DEATH <u>Aug. 20, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 18-02</u> | | | |
| c. Length of stay in Baltimore <u>Life</u> | | D. STREET ADDRESS (If rural, give location) <u>125 N. Carrollton Ave.</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <u>May 1, 1946</u> | 9. AGE (In years last birthday) <u>4</u> | 10. Under 1 Year: Months _____ Days _____ 11. Under 24 Hours: Hours _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>James Vanderford.</u> | | 14. MOTHER'S MAIDEN NAME <u>Nancy Tennessee</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Nancy Vanderford, 125 N. Carrollton Ave.</u> | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. <u>754.4</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Congestive heart failure</u> DUE TO</p> <p>ANTECEDENT CAUSES (B) <u>Congenital heart disease.</u> DUE TO</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 50%;"> <p>CAUSE OF DEATH</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>7/1/50</u> , 19__, to <u>8/20/50</u> , 19__, that I last saw the deceased alive on <u>8/20/50</u> , 19__, and that death occurred at <u>1:25 P.M.</u> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>J. E. Sumner</u> | | 23B. ADDRESS M. D. <u>University Hospital</u> | | 23C. DATE SIGNED <u>8/20/50</u> | |
| 24A. BURIAL OR CREMATION. REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-24-1950</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbatus Memorial</u> | |
| 24D. LOCATION City, town, or county (State) <u>Md.</u> | | 24E. NAME OF CEMETERY OR CREMATORY <u>Arbatus</u> | | 24F. LOCATION City, town, or county (State) <u>Md.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 22 1950</u> | | REGISTRAR'S SIGNATURE <u>John Williams</u> | | 25. FUNERAL DIRECTOR <u>Mrs. Katie R. Williams</u> | |
| ADDRESS <u>Schroeder St</u> | | ADDRESS <u>Schroeder St</u> | | ADDRESS <u>Schroeder St</u> | |

CERTIFICATE OF BIRTH

State of New York

County of _____

City of _____

I, _____

do hereby certify that _____

was born on _____

at _____

to _____

and _____

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7265
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN SMALL

2. DATE
OF
DEATH

8-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

PROVIDENT HOSPITAL

D. STREET ADDRESS (If rural, give location)

622 W. SARATOGA ST.

c. Length of stay in Baltimore

20

5. SEX

MALE

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

OCT 1912

9. AGE (In years, last birthday)

37 38

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

COOK

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

11. BIRTHPLACE (State or foreign country)

FLORENCE S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

BESSIE

P

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, none known)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

John Small

622 W. Saratoga St.

18. **445X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

UREMIA

4 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

MALIGNANT HYPERTENSION

8 MOS.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on **8-20**, 19**50**, and that death occurred at **6:50 AM.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

J. H. Pinney

M. D.

Provident Hospital

8-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

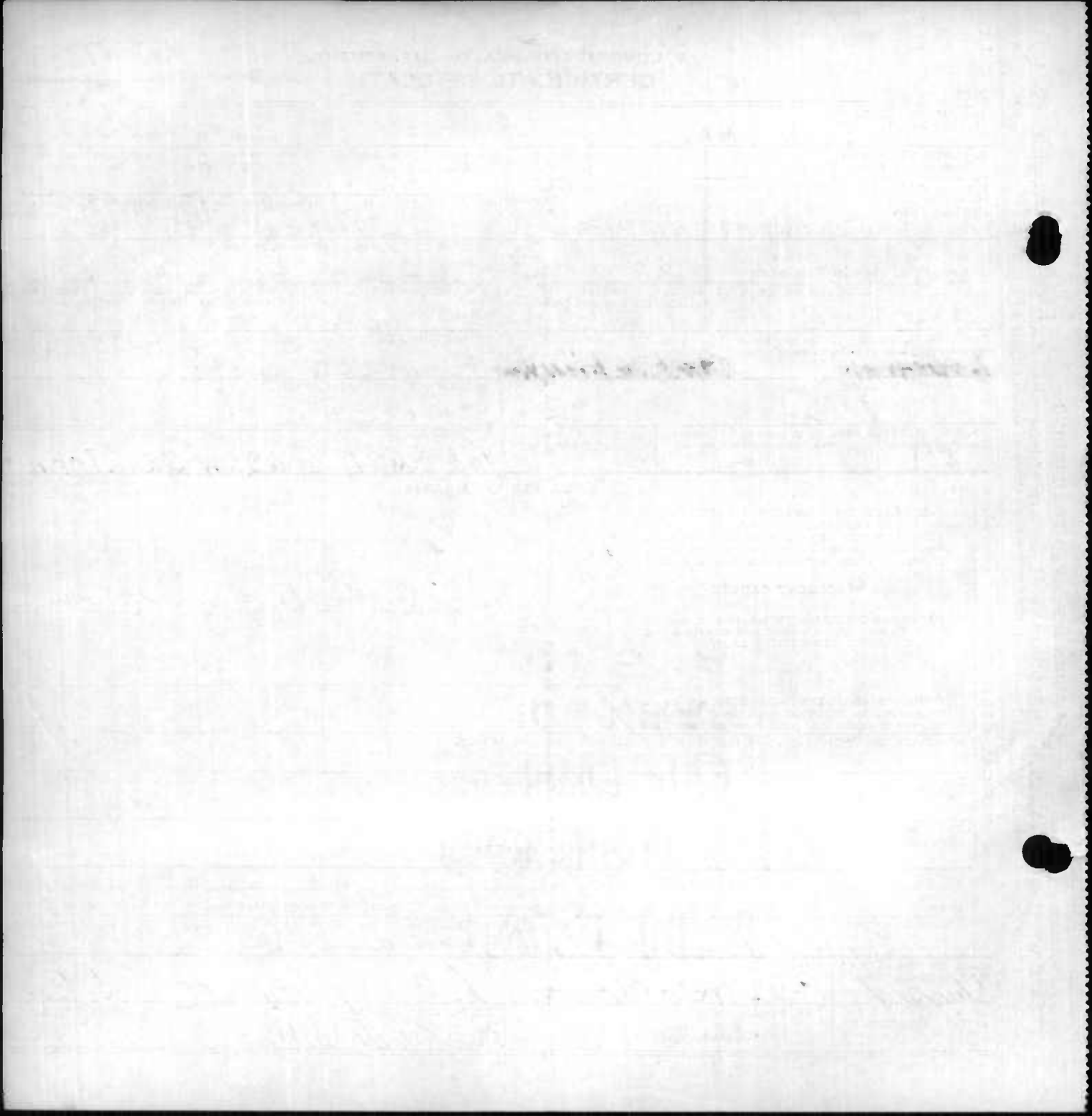
25. FUNERAL DIRECTOR

ADDRESS

AUG 22 1950

Thurston Williams

Mrs. Katie R. Williams, Schenck St.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7266

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Hannah Callanan

2. DATE
OF
DEATH

August 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONBaltimore City Hospitals
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1716 E. Oliver St.

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 4, 1875

9. AGE (in years
last birthday)

74

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Callanan

14. MOTHER'S MAIDEN NAME

Anne Mooney

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18.

E9020 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute Pulmonary Edema

DUE TO

7 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Stanley H. Dubinski*
for C.J. Lubinski, M.D.
(C) CHIEF OR ASST. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Fractured neck of Humerus - Bilateral

2 days

19A. DATE OF OPERATION

8-18-50

19B. MAJOR FINDINGS OF OPERATION

Closed Reduction under Brachial Plexus Block

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1716 E. Oliver St.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

5:AM August 18, 1950

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

Patient fell out of bed

22. I hereby certify that I attended the deceased from August 18, 1950 to August 20, 1950 that I last saw the
deceased alive on August 20, 1950 and that death occurred at 8:40 PM from the causes and on the date stated above.

23A. SIGNATURE

John A. Moore

M. D.

23B. ADDRESS

4940 Eastern Ave

23C. DATE SIGNED

August 21-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

ADDRESS

John A. Moore

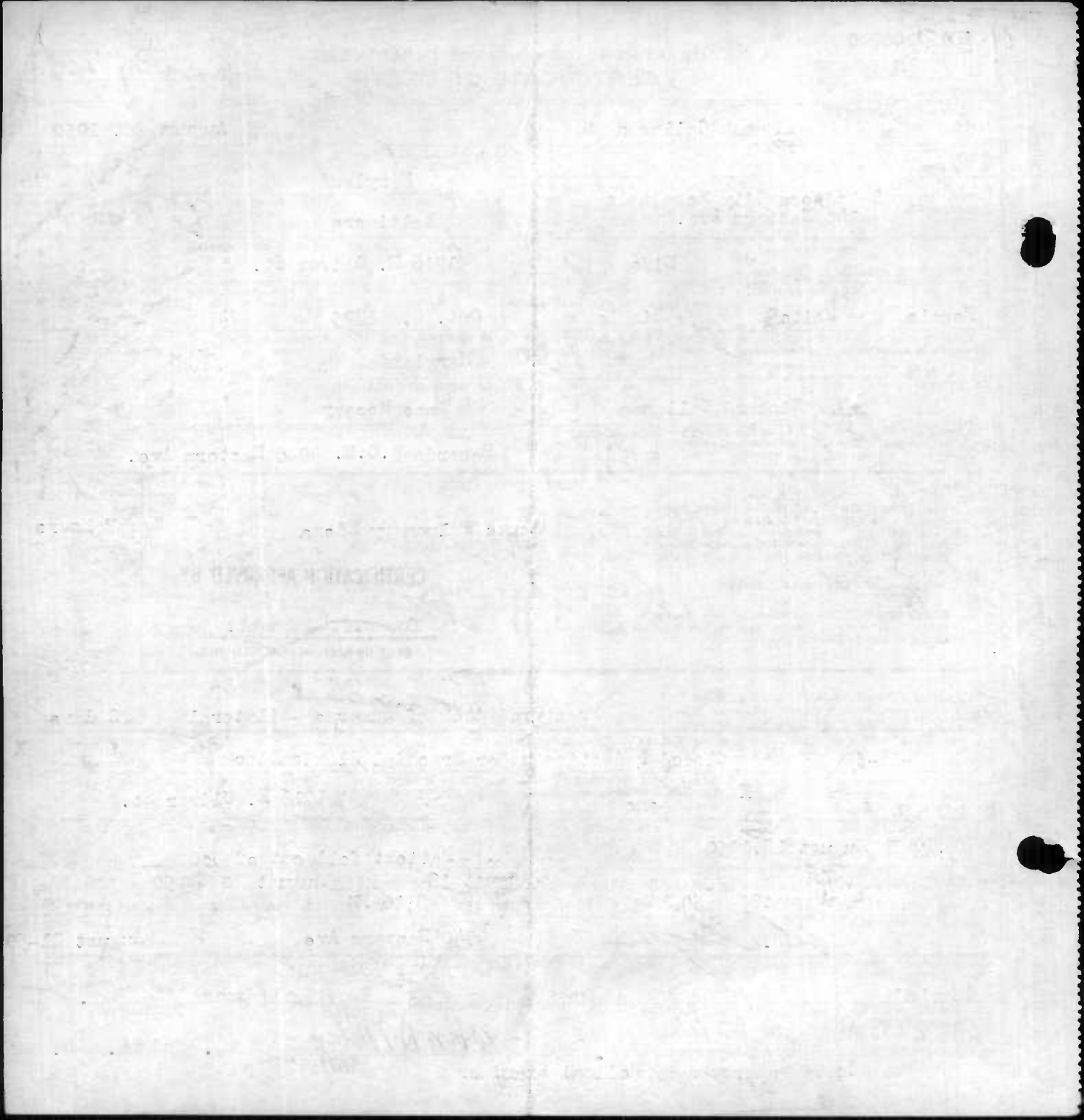
3000 E. Balto. St.

VS 150

To be approved by Medical Examiner

N-812.0

186a



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7267

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jessie Hadfield

2. DATE
OF
DEATH

Aug. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

911 N. Streeper St.

C. CITY OR TOWN (If outside corporate limits of the RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

911 N. Streeper St.

C. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

7-9-1875

9. AGE (In years
last birthday)

75

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

St.

Mrs. Jessie Shutt 911 N. Streeper

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. A. Kammer, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☐MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

Aug. 20, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-23-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

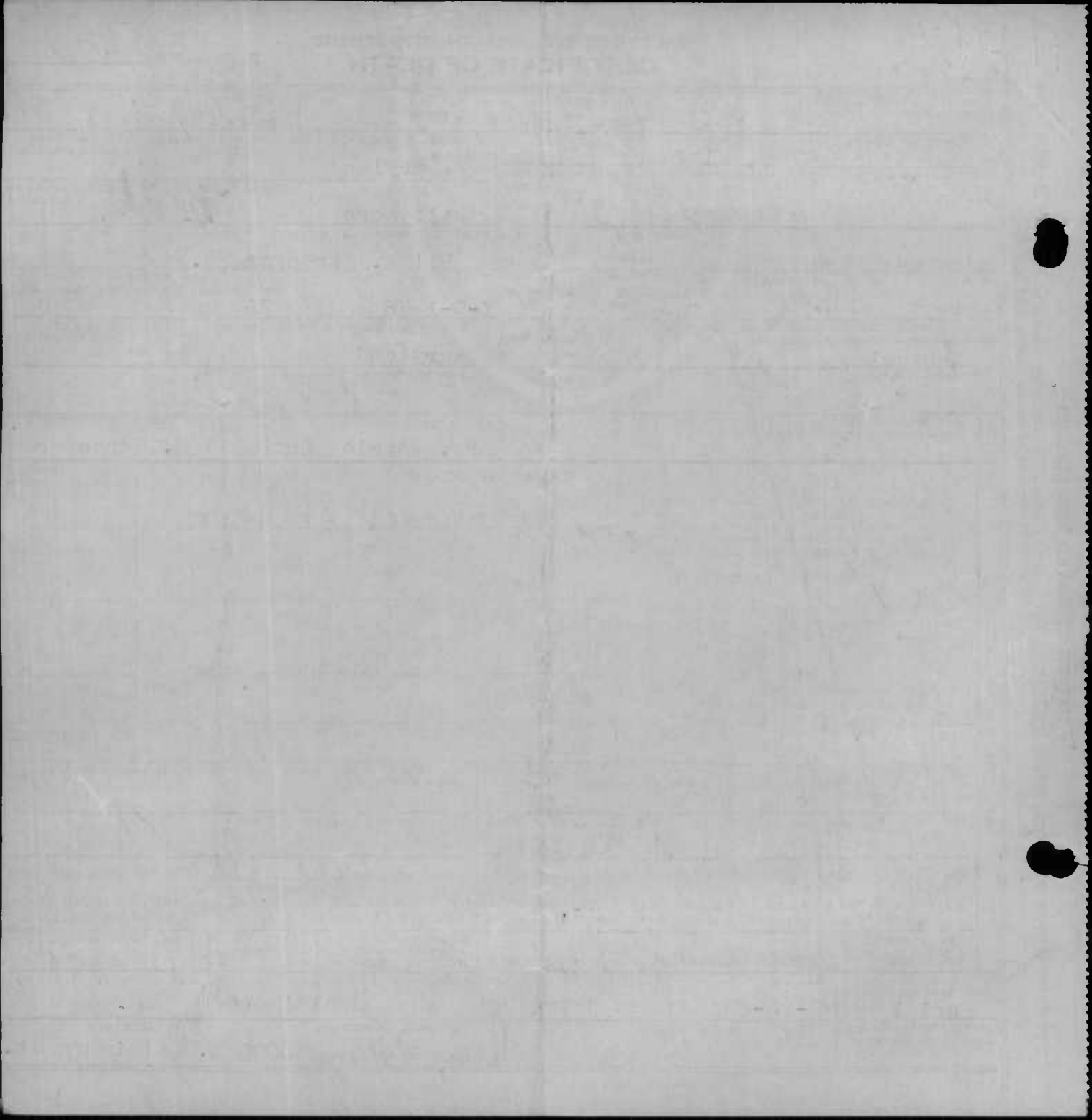
William A. Kammer, Jr.

25. FUNERAL DIRECTOR

John A. Moran

ADDRESS

3000 E. Baltimore St.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-17346

1. NAME OF DECEASED
(Type or Print)

Baby Boy Donovan

2. DATE
OF
DEATH

8-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

40 St Agnes' Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Riggs Ave - Severna Pk

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

8-17-50

9. AGE (In years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

2

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert Donovan

14. MOTHER'S MAIDEN NAME

Katherine Link

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 751.X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Meningo encephalocle
congenital

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-17, 1950, to 8-19, 1950, that I last saw the
deceased alive on 8-19, 1950, and that death occurred at 8:35 P. M., from the causes and on the date stated above.

23A. SIGNATURE

John J. Fisher M.D.

23B. ADDRESS

St Agnes Hospital

23C. DATE SIGNED

8-20-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/21/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams M.D.

25. FUNERAL DIRECTOR

ADDRESS

M. Fahy & Sons 401 SUFFOLK Rd.

Inquire if

meningo-encephalocele,

congenital mass of

syphilitic origin

"Non-syphilitic"

see Document File 50 - 7268

Es 9-5-50

J

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Michelina Reale

2. DATE
OF
DEATH

August 19 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **4107 Marx Ave**

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-01

D. STREET ADDRESS (If rural, give location)

4107 Marx Ave

c. Length of stay in Baltimore

44 Yrs

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

8. DATE OF BIRTH

April 1st 1882

9. AGE (In years, last birthday)

68

If Under 1 Year Months: Days

4

If Under 24 Hours Hours: Min.

18

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Vincent Palmieri

14. MOTHER'S MAIDEN NAME

Mary Anello

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Anthony Reale Sr. 4107 Marx Ave

18. **4201**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Coronary Occlusion**

30 min

ANTECEDENT CAUSES

Coronary Disease

Unknown

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Unknown

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **Arterio-Sclerosis**

Unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 17, 1948** to **August 19, 1950**, that I last saw the deceased alive on **Aug. 19, 1950**, and that death occurred at **11²⁰ p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

Philip Anteziani

M. D.

23B. ADDRESS

2942 E. Fayette St.

23C. DATE SIGNED

8/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

August 23 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Ceme. 4430 Belair Rd. Baltimore Md.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY

AUG 23 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Frank Delloskoe

ADDRESS

322 S. High St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

August 19 1950

Washington, D.C.

1107 Main Ave

Baltimore

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

1107 Main Ave

August 22 1950

1107 Main Ave

8-300
50 7270

50 7270

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

| | | | | | |
|---|----------------------------------|--|--------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Aaron T. Dyott | | 2. DATE OF DEATH 8-21-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY City | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 1738 Harford Avenue | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| c. Length of stay in Baltimore Life | | D. STREET ADDRESS (If rural, give location) 1738 Harford Avenue | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 12-7-1876 | 9. AGE (In years last birthday) 73 | H Under 1 Year Months Days 8 14 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger | | 10B. KIND OF BUSINESS OR INDUSTRY Paperhanging | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME James Dyott | | 14. MOTHER'S MAIDEN NAME Martha Fairbanks | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Mrs. Lillian Amelia Dyott 1738 Harford Avenue | |
| 18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular Disease DUE TO (B) Acute Coronary Occlusion DUE TO (C) 3 days | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Jan. 15 , 19 48 to Aug. 21 , 19 50 , that I last saw the deceased alive on Aug. 19 , 19 50 , and that death occurred at m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Samuel B. Wolfe | | 23B. ADDRESS 1331 North Ave | | 23C. DATE SIGNED 8-21-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-23-50 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | | 25. FUNERAL DIRECTOR ADDRESS George J. Ruth, Inc. 1735 Harford Avenue | | | |

56524

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
CENTERS FOR DISEASE CONTROL AND PREVENTION

NAME (Last, first, middle initial) _____

DATE OF BIRTH (Month, day, year) _____

SEX (Male, Female) _____

ADDRESS (Street, city, state, zip) _____

PHONE (Area code, number) _____

DATE OF EXAMINATION (Month, day, year) _____

EXAMINER (Name, title) _____

TEST RESULTS (Positive, Negative, Indeterminate) _____

REMARKS (Additional information) _____

SIGNATURE (Examiner) _____

DATE (Month, day, year) _____

TEST KIT (Brand, lot number) _____

LABORATORY (Name, address, phone) _____

TEST TYPE (Serum, Urine, Saliva) _____

TEST METHOD (Enzyme immunoassay, Western blot) _____

TEST RESULT (Positive, Negative, Indeterminate) _____

REMARKS (Additional information) _____

SIGNATURE (Examiner) _____

DATE (Month, day, year) _____

TEST KIT (Brand, lot number) _____

LABORATORY (Name, address, phone) _____

TEST TYPE (Serum, Urine, Saliva) _____

TEST METHOD (Enzyme immunoassay, Western blot) _____

TEST RESULT (Positive, Negative, Indeterminate) _____

REMARKS (Additional information) _____

SIGNATURE (Examiner) _____

DATE (Month, day, year) _____

TEST KIT (Brand, lot number) _____

LABORATORY (Name, address, phone) _____

TEST TYPE (Serum, Urine, Saliva) _____

TEST METHOD (Enzyme immunoassay, Western blot) _____

TEST RESULT (Positive, Negative, Indeterminate) _____

REMARKS (Additional information) _____

SIGNATURE (Examiner) _____

DATE (Month, day, year) _____

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7271

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM DERUFF

2. DATE
OF
DEATH

August 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Maryland

B. COUNTY

Anne Arundel

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Lake Shore, Pasadena

D. STREET ADDRESS (If rural, give location)

1217 Maryland Avenue

c. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1880

9. AGE (In years

80

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of

work done during most of working life, even if retired)

Retired Butcher

10B. KIND OF BUSINESS OR
INDUSTRY

Own

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frederick De Ruff

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Collins 2612 Garrett Ave

18. E823.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Fracture of neck

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Mountain Road 1 mile south of Lipin's

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 22, 1950 9.15 a.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto which skidded off road

22. I certify that I took charge of the remains described above, held an autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Divillos, M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

August 22, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/25/50

24C. NAME OF CEMETERY OR CREMATORY

St. Johns (Waverly)

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 23 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm Cook Inc. 1217 St. Paul St.

ADDRESS

CERTIFICATE OF DEATH

Regulation 10

A FORM FOR THE REGISTRATION OF DEATHS

1. Name of deceased (Print name in full)
2. Sex
3. Date of birth (Day, month, year)
4. Date of death (Day, month, year)
5. Place of death (Full address)
6. Cause of death (Full description)
7. Signature of Registrar (Print name and sign)
8. Signature of Medical Officer (Print name and sign)
9. Signature of Coroner (Print name and sign)
10. Signature of Police Officer (Print name and sign)
11. Signature of Family Member (Print name and sign)
12. Signature of Priest (Print name and sign)
13. Signature of Minister of Religion (Print name and sign)
14. Signature of Other (Print name and sign)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7272

BIRTH NO. 50-00666

| | | | |
|--|---------------------------|---|---------------------------------------|
| 1. NAME OF DECEASED (Type or Print) EUGENE QUEEN | | 2. DATE OF DEATH August 20, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION 949 W. Lombard Street | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-03 | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 949 W. Lombard Street | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | B. DATE OF BIRTH Jun 1st 1950 7 Mo |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Thomas Queen | | 14. MOTHER'S MAIDEN NAME Betty Herd | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. INFORMANT ADDRESS Angie Perry 821 W. Lombard St. | |
| 16. SOCIAL SECURITY NO. | | | |

| | | |
|---|----------------------------|----------------------------------|
| 18. 7272 | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Malnutrition DUE TO | |
| ANTECEDENT CAUSES | (B) DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 949 W. Lombard Street | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Since birth | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Neglect by imbecilic mother | |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> . | | | | | |
| 23A. SIGNATURE William V. Lovitt | | 23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR..... | | 23C. DATE SIGNED 8-21-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/24/50 | | 24C. NAME OF CEMETERY OR CREMATORY Western | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 24E. DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1950 | | 25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St. Paul St. | |
| 24F. REGISTRAR'S SIGNATURE Washington Williams, M.D. | | 24G. DATE 8-21-50 | | 24H. TIME 158 | |

51134-05

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ann Waxter Rector

2. DATE
OF
DEATH

Aug. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

none

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

201 E. University Parkway

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

201 E. University Parkway

C. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Jan. 1876

9. AGE (In years
last birthday)

74

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

William P. Waxter

14. MOTHER'S MAIDEN NAME

Elizabeth M. Sprucebank

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Judge Thos. J. S. Waxter - 4721 East Lane

18.

420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

1 hr

year

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/17, 1950, to 8/21, 1950, that I last saw the
deceased alive on 8/21, 1950, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

25 W. Penna. Ave., Towson, Md.

8 - 22 - 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

cremation

24B. DATE

8/23/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 23 1950

Huntington Williams, M.D.

John O. Mitchell & Sons, Inc. - 1900 Eutaw Place

J. O. Mitchell

VS 150

Dr. McShane

94a

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7274

| | | | | | |
|--|---------------------------|---|--|--------------------------------------|-------------------------------|
| BIRTH NO. 49-07157 | | 1. NAME OF DECEASED (Type or Print) Martha Henrietta Dixon | | 2. DATE OF DEATH 8-22-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 21 Baltimore City Hospitals | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-03 | | |
| C. Length of stay in Baltimore Life Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 943 N. Mount Street (17) | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDDED, DIVORCED (Specify) Single | 8. DATE OF BIRTH Mar. 27, 1949 | 9. AGE (in years last birthday) 1 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Armond Kimbough | | | 14. MOTHER'S MAIDEN NAME Mary Dixon | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS 4940 Records* Balto. City Hospitals Eastern Ave. | | |

| | | | |
|--|---|---|--|
| MEDICAL CERTIFICATION | 18. 002X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Tuberculous Meningitis (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 4 Mos. |
| | ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Pulmonary & Lymphnode Tuberculosis (B) DUE TO | | |
| | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| | 19A. DATE OF OPERATION 2 | | 19B. MAJOR FINDINGS OF OPERATION |
| | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from 5-16 19 50 to 8-22 19 50, that I last saw the deceased alive on 8-22 19 50, and that death occurred at 10:30 A. M., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE D. S. Rogers | | 23B. ADDRESS 4940 Eastern Avenue | 23C. DATE SIGNED 8-22-50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Cremial | 24B. DATE 8/24/50 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | 24D. LOCATION (City, town, or county) (State) Westport, Balto. Md. |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1950 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc. 927 N. Mount St. 13B | |

[Faint handwritten notes at the bottom of the page]

W-43 CERTIFICATE CORRECTED 9-5-50 Wild

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7275

| | | | |
|--|------------------|--|---|
| BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| Christian G Wild | | Aug 21-1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| Ba 1 to Md. | | A. STATE B. COUNTY | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| St. Josephs Hosp | | BALTO | |
| D. STREET ADDRESS (If rural, give location) | | 5839 Belair Rd 26-01 | |
| c. Length of stay in Baltimore | | BALTO-Md | |
| 51-yrs | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH |
| M | W | Married | 1876 Jan 22 - (47-74) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| Plumber | | OWN BUSINESS | Germany |
| 13. FATHER'S NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Christian Wild | | AMERICAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| No | | NONE | Mr Adolph Wild 5839 Belair Rd |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | 2 hrs |
| (A) DUE TO | | | Coronary occlusion |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (B) DUE TO |
| | | | Hypertensive Cardiovascular Disease |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO |
| | | | Generalized arteriosclerosis |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | |
| 0 | | | |
| 20. AUTOPSY? | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| | | | |
| 22. I hereby certify that I attended the deceased from Sept 8, 1946 to August 21, 1950, that I last saw the deceased alive on Aug 11, 1950, and that death occurred at 9 p.m., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE | | 23B. ADDRESS | |
| Max R. English | | 5713 Belair Rd Balto | |
| M. D. | | 8-22-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Burial | | Thurs 24-1950 | |
| 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Baltimore Cemetery | | BALTO - MD | |
| DATE RECEIVED BY LOCAL REGISTRAR | | 25. FUNERAL DIRECTOR ADDRESS | |
| AUG 23 1950 | | Lassahn Funeral Home Balair Rd | |
| REGISTRAR'S SIGNATURE | | | |
| Thurston Williams, M.D. | | | |

VS 150

NOTE: Dr. Davis Crown on duty was called in case - 93D

CERTIFICATE OF DEATH

DECEASED

DATE

PLACE

CAUSE

AGE

SEX

RACE

RELATION

OCCUPATION

EDUCATION

RESIDENCE

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

| | | | | | |
|---|-------------------------------|---|---|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Christianne Wansch</i> | | | 2. DATE OF DEATH <i>Aug 20, 1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1010 N. Patterson Pk</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>8-04</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>DO</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> | | |
| c. Length of stay in Baltimore <i>LIFE</i> | | | D. STREET ADDRESS (if rural, give location) <i>1010 N. Patterson Pk.</i> | | |
| 5. SEX <i>F.</i> | 6. COLOR OR RACE <i>W.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i> | 8. DATE OF BIRTH <i>Oct. 29-1868</i> | 9. AGE (In years last birthday) <i>81</i> | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> |
| 13. FATHER'S NAME <i>Unknown</i> | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | 17. INFORMANT <i>Eugene Monfalcone</i> | | |
| | | | ADDRESS <i>3814 Lyndale Ave.</i> | | |

| | | | | |
|---|--|--|---------------|----------------------------------|
| 18. <i>331X</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Broncho pneumonia</i> | <i>3 days</i> | |
| ANTECEDENT CAUSES | | (B) <i>Cerebral Hemorrhage & paralysis</i> | <i>8/9/50</i> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) <i>Arterio-sclerosis generalized?</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |

| | | | | |
|--|---|--|---|---|
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from <i>8/9</i> , 1950, to <i>8/20</i> , 1950, that I last saw the deceased alive on <i>8/19</i> , 1950, and that death occurred at <i>10:15</i> a.m., from the causes and on the date stated above. | | | | |
| 23A. SIGNATURE <i>Louis F. Kleines</i> | 23B. ADDRESS <i>2623 E. Monument St</i> | 23C. DATE SIGNED <i>8/24/50</i> | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>Aug. 23-1950</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Oakblain Cemetery</i> | 24D. LOCATION (City, town, or county) <i>Baltimore</i> | (State) <i>Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 23 1950</i> | REGISTRAR'S SIGNATURE <i>Huntington Williams, Md.</i> | 25. FUNERAL DIRECTOR <i>John C. Miller, Inc 2435 E. Oliver St</i> | | |

VS 150

Wls. Louis Kleines 2623 E. Monument

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

WALTER
CONCRETE
BUILD

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7277
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Joshua E Hudin

2. DATE
OF
DEATH

Aug. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE 9-07

D. STREET ADDRESS (If rural, give location)

1501 HOMESTEAD ST

B. FULL NAME OF HOSPITAL OR INSTITUTION

1501 HOMESTEAD ST

c. Length of stay in Baltimore

45 Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

9. AGE (in years last birthday)

72

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

GROGER

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Chaim

14. MOTHER'S MAIDEN NAME

Ethel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Marcy E Hudin - 3612 Cedarvale Rd

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary embolism*
DUE TO

instant

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Coronary Thrombosis*
DUE TO
(C)

4 years.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Renal plaque

2 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4-23*, 19*48*, to *8-22*, 19*50*, that I last saw the deceased alive on *8-21*, 19*50* and that death occurred at *3:00* p.m., from the causes and on the date stated above.

23A. SIGNATURE

A. A. S. Lina

23B. ADDRESS

Engle Gardens Apt.

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/24/1950

24C. NAME OF CEMETERY OR CREMATORY

HERRING RUN

24D. LOCATION (City, town, or county)

BALTO.

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JACK LEWIS Inc - 400 EOTAW PL.

AUG 23 1950

2906A

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~A. Silver
Temple Gordon~~

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7278

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Emory Kilmon

2. DATE
OF
DEATH

August 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived at institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

12-07

D. STREET ADDRESS (If rural, give location)

306 West 31st St.

c. Length of stay in Baltimore

65 Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

January 24, 1887

9. AGE (In years last birthday)

63

10 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Grocery store owner

10B. KIND OF BUSINESS OR INDUSTRY

Grocery store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Eddison Kilmon

14. MOTHER'S MAIDEN NAME

Julia Emory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Doris Zarriello

ADDRESS

306 W. 31st St.

18. *443X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Bilateral Cerebral Hemorrhage with complete Paraplegia

7 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardiovascular Disease

15 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Aug. 21*, 1950, to *Aug. 21*, 1950, that I last saw the deceased alive on *Aug 21*, 1950, and that death occurred at *7:19 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Alfred S. Nelson

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

August 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 24/50

24C. NAME OF CEMETERY OR CREMATORY

Morland Park

24D. LOCATION (City, town, or county)

Jaycoe Ave

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 23 1950

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Walter E. Donovan

ADDRESS

3818 Roland Ave

VS 150

2906A

93D

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Louis F. Spangler*2. DATE
OF
DEATH*Aug 21, 1950*3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution location)

University Hospital

c. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Md.*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 6, 27-01

D. STREET ADDRESS (If rural, give location)

4021 Ridgescroft Rd

5. SEX

Male

6. COLOR OR RACE

*white*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

3/8/81

9. AGE (in years last birthday)

*69*If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Miller

10B. KIND OF BUSINESS OR INDUSTRY

Paul Jones Machinery

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Andrew Spangler

14. MOTHER'S MAIDEN NAME

Elizabeth Lentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

219-01-6181

17. INFORMANT

Miss Mabel Spangler 4021 Ridgescroft

ADDRESS

18.

148X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Pulmonary edema*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Metastatic carcinoma of the lung*

DUE TO

(C) *Carcinoma of the pharynx*

INTERVAL BETWEEN ONSET AND DEATH

of minutes

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug 1*, 1950, to *Aug 21*, 1950, that I last saw the deceased alive on *Aug 21*, 1950, and that death occurred at *3:15 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Raymond Bradshaw, Jr.

M. D.

23B. ADDRESS

University Hospital, Balto

23C. DATE SIGNED

8/21/50

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Taylor Ave

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 23 1950

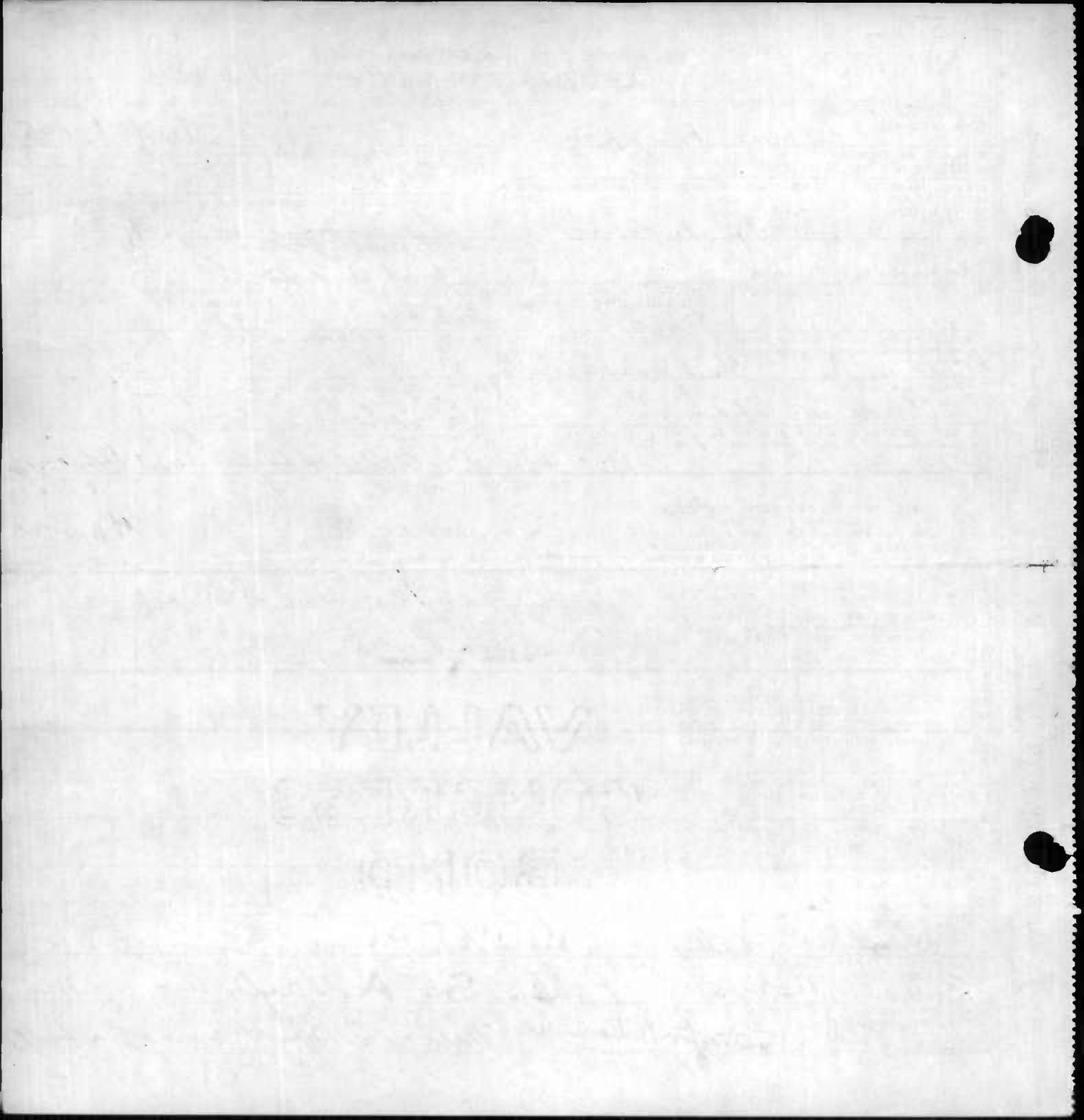
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Mildred J. Blight, 6009 Harford Rd.

ADDRESS



M 635
Dr. Janney
50 7280BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7280
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jennie L. Martin

2. DATE
OF
DEATH

Aug. 22. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

3008 Woodhome Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-05

D. STREET ADDRESS (If rural, give location)

7303 Harford Road

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Apr. 25, 1871

9. AGE (in years
last birthday)

79

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Troy, Ohio

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wm. Lucous

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. F.L. Annen, 7303 Harford Road.

18.

4201

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Heart Disease

10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis C.V.
Disease

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 10 1950 to Aug. 22, 1950, that I last saw the
deceased alive on Aug. 22, 1950, and that death occurred at 9:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Nathan Janney

M. D.

23B. ADDRESS

7101 Harford Rd.

23C. DATE SIGNED

8/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/26/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

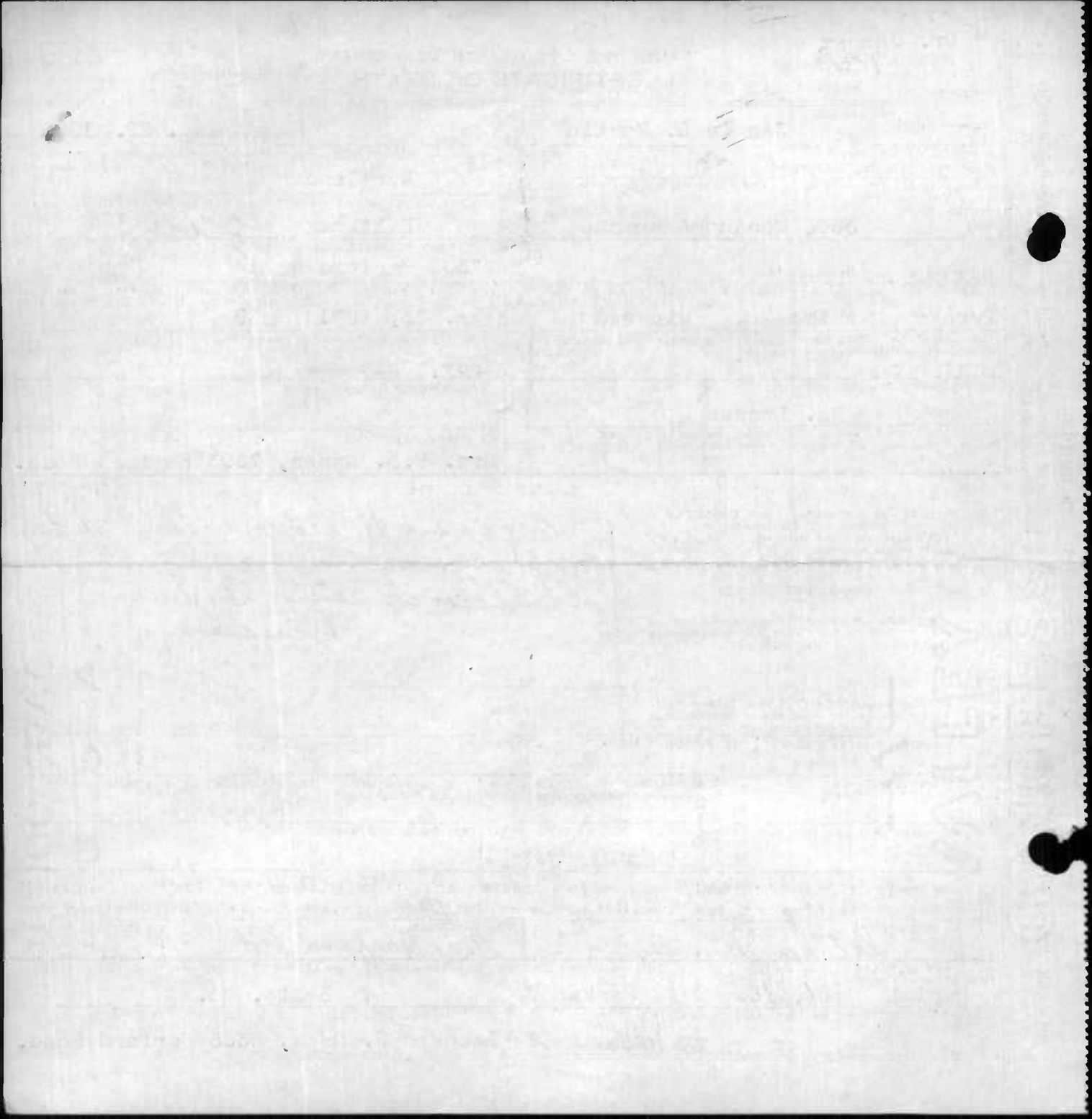
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Jaime L. Luck

2. DATE
OF
DEATH

Aug. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1136 Myrtle Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

17-03

D. STREET ADDRESS (If rural, give location)

1136 Myrtle Ave

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years; last birthday)

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work he did during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Warden

14. MOTHER'S MAIDEN NAME

Margaret Anne Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Margaret Luck Franklin

18.

442X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Myocardial Failure*

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Cardiovascular disease hypertension 1 year*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Aug. 18, 1950*, to *Aug. 21, 1950*, that I last saw the deceased alive on *Aug. 21, 1950*, and that death occurred at *8:10 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 23 1950

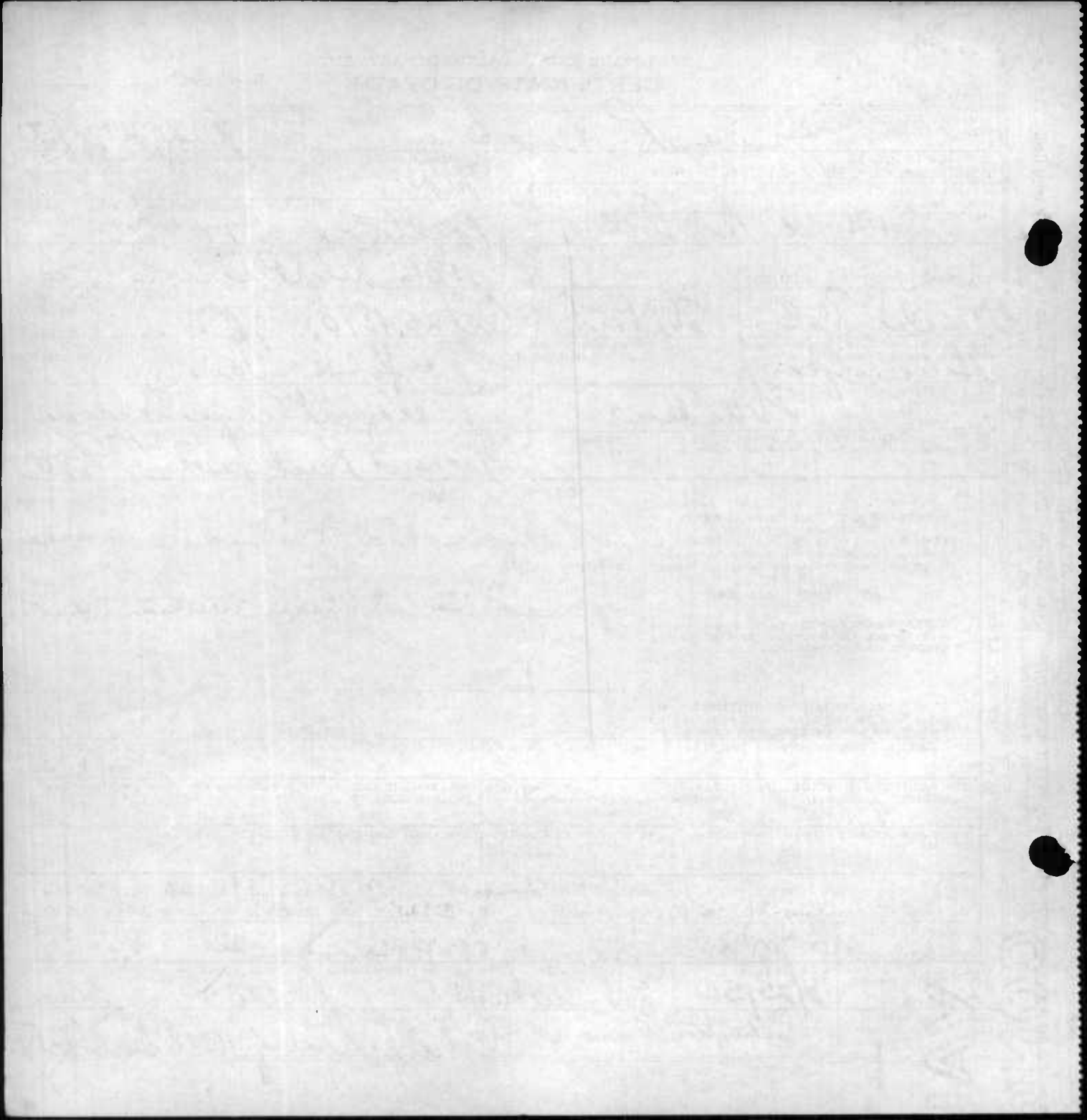
Wilmington Williams, M.D.

Robert H. Spring 1532 E. Monument St.

1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E-355
50 7282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7282
Registered No.

| | | | | | |
|---|---------------------------------|--|---------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Dillard Edmonds. 5463-95-</u> | | 2. DATE OF DEATH <u>AUG 20 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____ | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <u>Baltimore 12-07</u> | | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | D. STREET ADDRESS (If rural, give location) <u>2101 N. Howard St.</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u> | 8. DATE OF BIRTH <u>8-11-92</u> | 9. AGE (In years last birthday) <u>58</u> | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u> | | 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>Thomas Edmonds</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Lucy E. Johnson</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u> ADDRESS _____ | | | |
| 18. <u>202.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Thrombocytopenic</u> DUE TO <u>Lymphoma</u> DUE TO <u>Antecedent Causes</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>✓</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>8-8-1950</u> to <u>8-20-1950</u> , that I last saw the deceased alive on <u>8-20-1950</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | | 23C. DATE SIGNED <u>8-21-50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-24-50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore</u> | | 24E. STATE <u>Md.</u> | | 25. FUNERAL DIRECTOR <u>Mettraine T. Hensley</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 23 1950</u> | | REGISTRAR'S SIGNATURE <u>Huntington Williams</u> | | ADDRESS <u>578 W. [illegible]</u> | |

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2021

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— 10 —

Sm. 49.1021

12-2

... ..

N. 400
50 7283BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

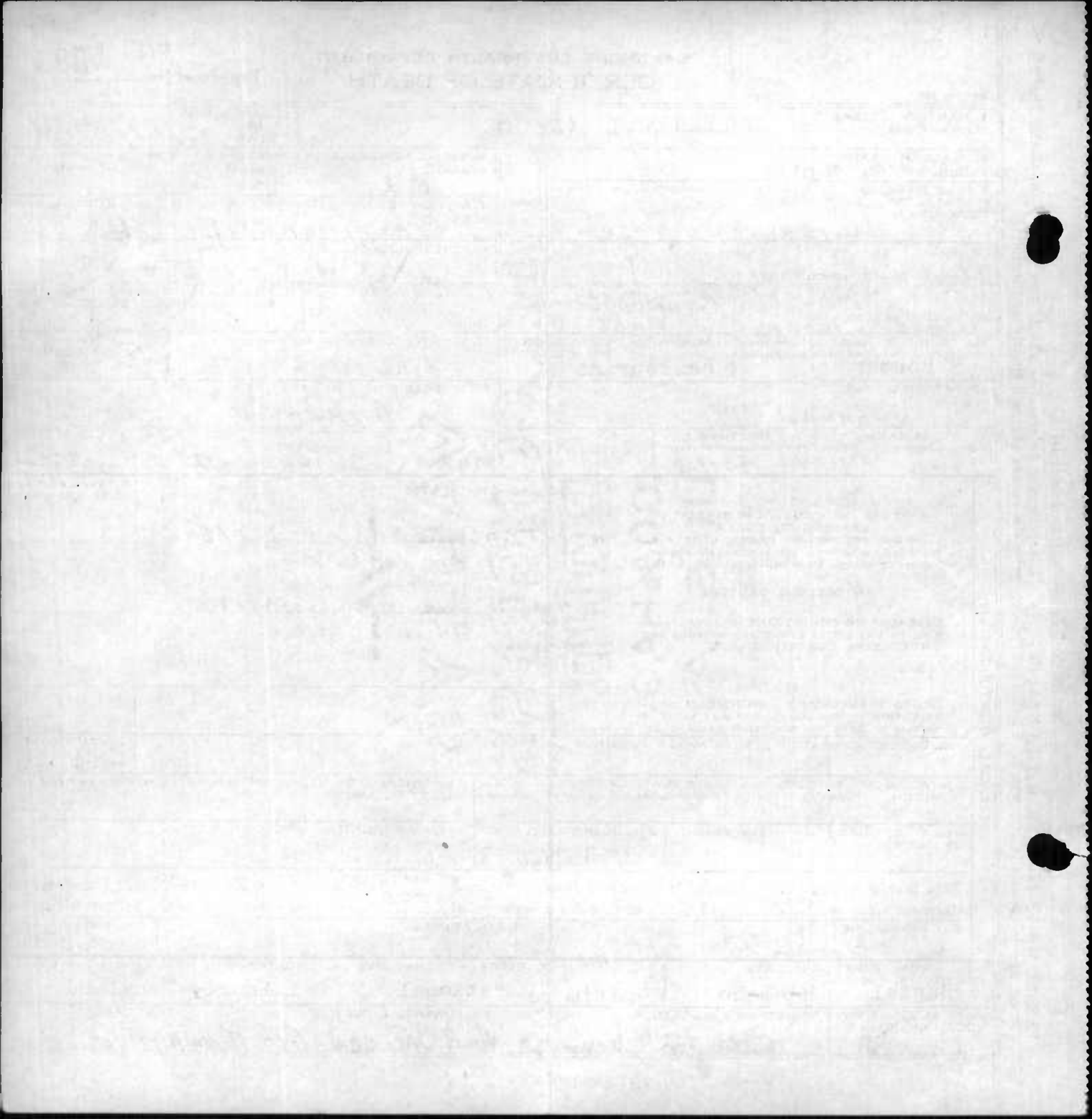
Registered No. 50 7283

| | | | |
|--|---|---|--|
| BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | STEPHEN NEAL (NEIL) | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 2. DATE OF DEATH 8/17/50 | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY | |
| C. Length of stay in Baltimore 9 Yrs. Mos. Days | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 19-12 D. STREET ADDRESS (If rural, give location) 1428 W. Fayette St. | |
| 5. SEX MALE | 6. COLOR OR RACE COLORED | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 5-7 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter | | 10B. KIND OF BUSINESS OR INDUSTRY Restaurant | 11. BIRTHPLACE (State or foreign country) VIRGINIA |
| 13. FATHER'S NAME UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO. | 14. MOTHER'S MAIDEN NAME UNKNOWN |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) 5/29/18 - 6/30/19 | | 17. INFORMANT ADDRESS MARVEL BOWERS 1428 W. Fayette St. | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) INTRACEREBRAL & SUBARACHNOID HEMORRHAGE DUE TO (B) Hypertensive - Arteriosclerotic CV Disease DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from 8/13, 1950 to 8/17, 1950, that I last saw the deceased alive on 8/17, 1950, and that death occurred at 9:55 P.M., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE Wm. A. Jackson | | 23B. ADDRESS Univ. Hosp. | 23C. DATE SIGNED 8/17/50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-23-50 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1950 | REGISTRAR'S SIGNATURE Wm. A. Jackson | 25. FUNERAL DIRECTOR ADDRESS Wm. A. JACKSON - 916 PENNA. AVE. | |

VS 150

7806M

93D



LC
82793

50 7284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7284
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Moran

2. DATE
OF DEATH Aug. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE Maryland B. COUNTY before admission)B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR Baltimore City Hospitals location)
INSTITUTION 4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore township)

c. Length of stay in Baltimore

50 Years

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

105 N. Carey Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 16, 1861

9. AGE (In years
last birthday)

88

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Moran (D)

14. MOTHER'S MAIDEN NAME

Ellen Killien ? (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Records* Baltimore City Hospitals
4940 Eastern Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease 1 Yr.
Possible Cerebral vascular accident 1 week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1943 to Aug. 19, 1950, that I last saw the
deceased alive on Aug. 19, 1950. and that death occurred at 4:13 Pm, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-22-50

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/22/50

24C. NAME OF CEMETERY OR CREMATORY

Catharine

24D. LOCATION (City, town, or county)

West Pomeroy Ro

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J J Zaleski and 1318 Light

ADDRESS

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7285

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DORIS L. BIDDLE

2. DATE OF DEATH
August 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1038 Wilmer Ct.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 9, 1925

9. AGE (In years last birthday)

25

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harry Biddle

14. MOTHER'S MAIDEN NAME

Lenora Reid

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Myrtle Thomas-800 George St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Functional disease of the heart with

~~myocardial~~ auricular fibrillation

ANTECEDENT CAUSES

(B) Intra-cardiac mural thrombi

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Pulmonary infarcts

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Dunleavy

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

August 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 23 1950

REGISTRAR'S SIGNATURE

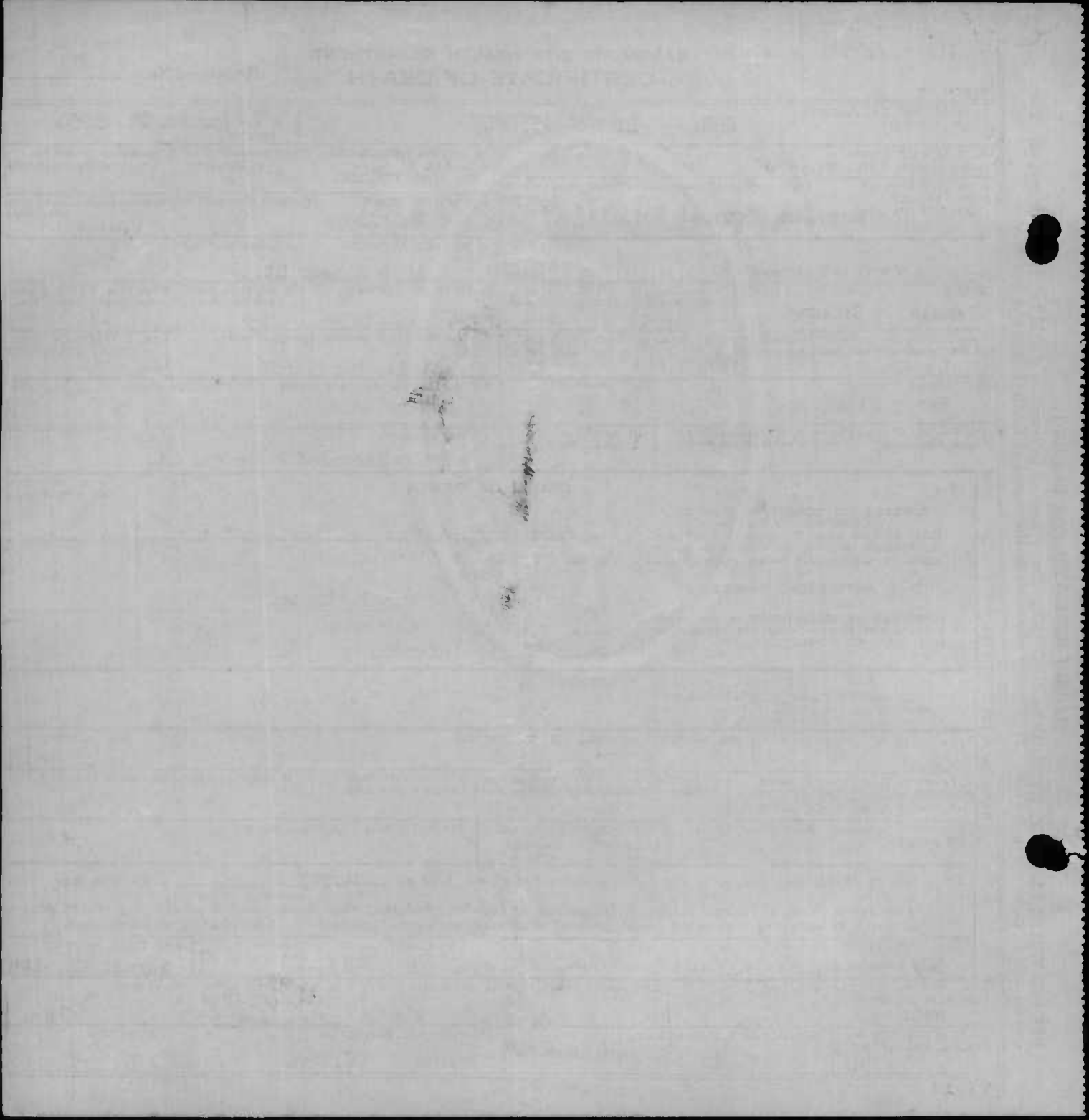
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Samuel W. Sullivan, Jr.

ADDRESS

1011 N. Arlington Ave.



5-460
50 7286BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7286

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Vattie M. Siler

2. DATE
OF
DEATH

Aug. 22-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3820 Wiltom Rd

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Ashburton Nursing Home

C. Length of stay in Baltimore

12 yrs.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

430 S. Furrow St

8. DATE OF BIRTH

3-18-1914

9. AGE (In years last birthday)

36

H Under 1 Year

Months Days

I Under 24 Hours

Hours Min.

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Joseph Bogdill

14. MOTHER'S MAIDEN NAME

Margaret Shettley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

-

17. INFORMANT

John E. Siler 430 S. Furrow St

ADDRESS

18.

153X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary of aorta

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 17, 1950, to Aug. 22, 1950, that I last saw the deceased alive on Aug 15, 1950, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

H. P. Friedman

23B. ADDRESS

1319 Lyster St.

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 25-1950

24C. NAME OF CEMETERY OR CREMATORY

Western Cemetery

24D. LOCATION (City, town, or county)

Balt Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Geo. E. Baeyer Jr, 1512 Hollins St

Balt 23 Md

AUG 23 1950

VS 150

46E

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. Name of Deceased: [Illegible]

2. Date of Death: [Illegible]

3. Place of Death: [Illegible]

4. Cause of Death: [Illegible]

5. Age of Deceased: [Illegible]

6. Sex of Deceased: [Illegible]

7. Marital Status: [Illegible]

8. Occupation: [Illegible]

9. Signature of Physician: [Illegible]

10. Signature of Registrar: [Illegible]

11. Date of Registration: [Illegible]

12. Place of Registration: [Illegible]

13. Name of Registrar: [Illegible]

14. Signature of Deceased: [Illegible]

15. Signature of Next of Kin: [Illegible]

16. Signature of Minister: [Illegible]

17. Signature of Coroner: [Illegible]

18. Signature of Jury: [Illegible]

19. Signature of Judge: [Illegible]

20. Signature of Sheriff: [Illegible]

21. Signature of Constable: [Illegible]

22. Signature of Undertaker: [Illegible]

23. Signature of Burial: [Illegible]

24. Signature of Interment: [Illegible]

25. Signature of Burial: [Illegible]

26. Signature of Interment: [Illegible]

27. Signature of Burial: [Illegible]

28. Signature of Interment: [Illegible]

29. Signature of Burial: [Illegible]

30. Signature of Interment: [Illegible]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7287

| | | | |
|--|---------------------------|---|--|
| BIRTH NO. <u>S-235</u> <u>50 7287</u> | | <u>SUCHTING</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>C. W. Henry Suchting</u> | | 2. DATE OF DEATH <u>Aug. 21, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto. Md.</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <u>Franklin Square Hosp.</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto. 28-04</u> | |
| c. Length of stay in Baltimore Yrs. <u>36</u> Mos. <u>10</u> Days | | D. STREET ADDRESS (If rural, give location) <u>504 Chapel Gate Lane</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married.</u> | 8. DATE OF BIRTH <u>Mar. 16, 1873</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasurer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Vegetable Canning</u> | 9. AGE (In years last birthday) <u>77</u> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. |
| 11. FATHER'S NAME <u>William Suchting</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. MOTHER'S MAIDEN NAME <u>Marie Miller</u> | | 14. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-05-3377</u> | |
| 17. INFORMANT <u>Mr. Carl Suchting</u> | | ADDRESS <u>504 Chapel Gate Lane</u> | |
| 18. <u>199.5</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinomatous</u> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Primary site unknown.</u> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>7/19/50</u> | | 19B. MAJOR FINDINGS OF OPERATION <u>Laminectomy. Extracranial metastatic carcinoma</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I hereby certify that I attended the deceased from _____, 19____, to <u>21 Aug.</u> , 19 <u>50</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:25 P.M.</u> , from the causes and on the date stated above. | |
| 23A. SIGNATURE <u>Edwin W. Landerbach</u> M. D. | | 23B. ADDRESS <u>Franklin Square Hosp.</u> | |
| 23C. DATE SIGNED <u>8/21/50</u> | | 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 24B. DATE <u>8/24/50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u> | |
| 24D. LOCATION (City, town, or county) <u>Violetville, Md.</u> | | 25. FUNERAL DIRECTOR <u>Edm. J. Pickner & Sons, Balto. Md.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>Aug 23 1950</u> | | REGISTRAR'S SIGNATURE <u>Wm. J. Williams, M.D.</u> | |

REPORT OF THE
COMMISSIONER OF HEALTH



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7288

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARROLL K. YEWELL

2. DATE
OF
DEATH

8/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 504 E. Clement St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE B. COUNTY before admission)

Md.

5. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

24-02

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

504 E. Clement Street

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

1/7/1871

9. AGE (In years
last birthday)

79

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Supt.

10B. KIND OF BUSINESS OR
INDUSTRY

Balto. Copper Paint

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William T.

14. MOTHER'S MAIDEN NAME

Elizabeth J. Slemaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Cerebral Hemorrhage

DUE TO

(B)

Arteriosclerosis

DUE TO

(C)

Hypertension - vascular Disease

INTERVAL BETWEEN
ONSET AND DEATH

8/5-8/20

15 yrs.

18 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

Walter Kohn

M. D.

23B. ADDRESS

102 E. Fort Ave

23C. DATE SIGNED

8/21/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

B

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore

ADDRESS

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

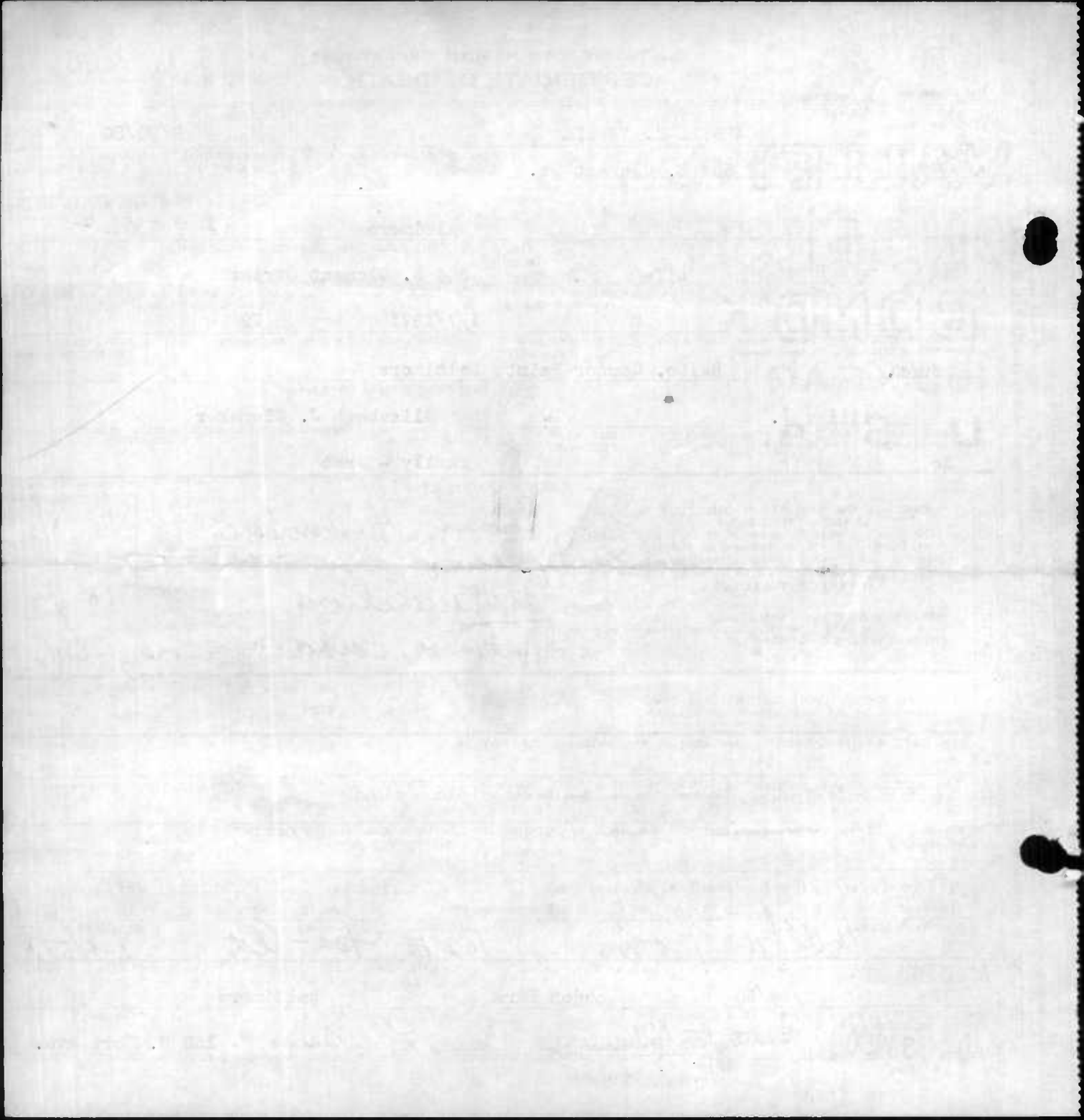
James L. McCreary

- 130 E. Fort Ave.

AUG 23 1950

VS 150

937



50 7289

W-532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7289

Registered No.

BIRTH NO.

| | | | | | |
|---|-------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Sherman R. Wentz M.D.</i> | | | 2. DATE OF DEATH <i>August 21/50</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2601 Manhattan Ave</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-19</i> | | |
| C. Length of stay in Baltimore <i>about 65 yrs.</i> | | | D. STREET ADDRESS (If rural, give location) <i>2601 Manhattan Ave</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>July 2, 1871</i> | 9. AGE (In years, last birthday) <i>79</i> | If Under 1 Year Months: Days Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Georgia, Ill.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Elias Wentz</i> | | | 14. MOTHER'S MAIDEN NAME <i>Charlotte Rinneberg</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i> | | 16. SPECIAL SECURITY NO. <i>Wood War I.</i> | 17. INFORMANT ADDRESS <i>Mrs Carrie E. Wentz 2601 Manhattan Ave</i> | | |

| | | |
|--|--|----------------------------------|
| 18. <i>153X</i> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <i>Metastatic Carcinoma of Liver & lungs</i> | <i>6 months</i> |
| ANTECEDENT CAUSES | (B) <i>Carcinoma of sigmoid</i> | <i>5 yrs</i> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|--|---|--|---|---|--|
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>May 1</i> , 19 <i>50</i> , to <i>August 21</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Aug 21</i> , 19 <i>50</i> , and that death occurred at <i>8:00 p.m.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Charles Stewart</i> | | 23B. ADDRESS <i>6 E. Read St</i> | | 23C. DATE SIGNED <i>Aug. 23-50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE <i>Aug 24/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i> | 24D. LOCATION (City, town, or county) <i>Pikesville, Md</i> | (State) | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 23 1950</i> | REGISTRAR'S SIGNATURE <i>William Williams</i> | 25. FUNERAL DIRECTOR <i>Loring Byers</i> | | ADDRESS <i>5805th Hpts 46E Re.</i> | |

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORANDUM FOR THE SECRETARY OF DEFENSE
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]

4. [Illegible]
5. [Illegible]
6. [Illegible]

7. [Illegible]
8. [Illegible]
9. [Illegible]
10. [Illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7290
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELIZAH

WATKINS

2. DATE
OF
DEATH

August 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1602 E. Biddle St.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Nov 15 1934

9. AGE (In years last birthday)

15

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Boy

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Moses Watkins

14. MOTHER'S MAIDEN NAME

Virginia Massey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Virginia Watkins 1602 E. Biddle

18. E 929.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Pool

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Druid Hill Park Pool

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Aug. 21, 1950 4:15 P.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Went swimming and couldn't swim

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley A. Dureacher M.D.

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED

August 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 25/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem

24D. LOCATION (City, town, or county)

W. A. County Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

Mrs. Robert G. Elliott

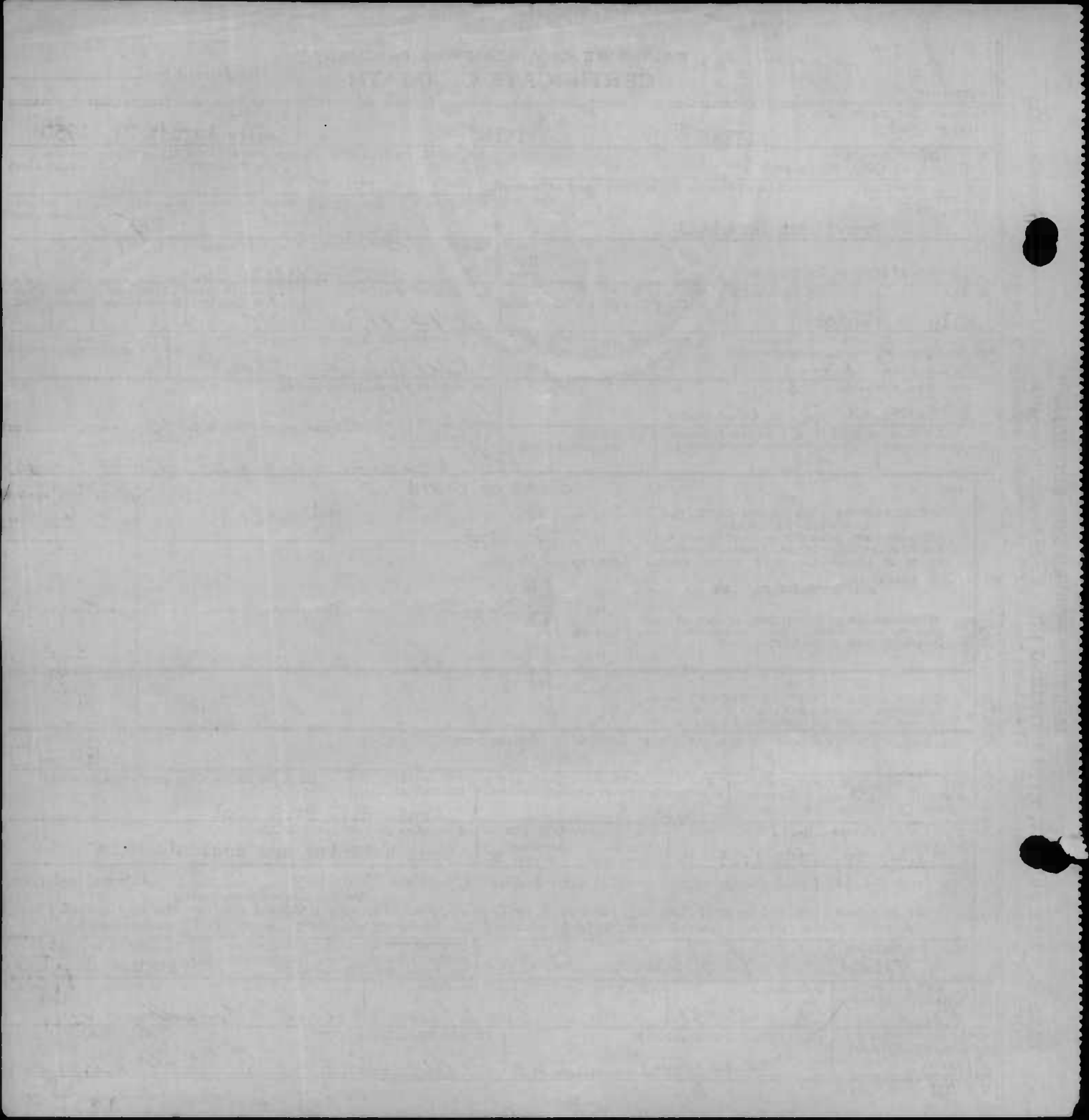
ADDRESS

183 1129 N. Caroline St

AUG 23 1950

N-990X

183 1129 N. Caroline St



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7291

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Anthony

2. DATE
OF
DEATH

8-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

100 N. Bruce St

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

19-02

D. STREET ADDRESS (If rural, give location)

100 N. Bruce St

c. Length of stay in Baltimore

Yrs.
Mos.
Days

30

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9-8-1900

9. AGE (In years
last birthday)

49

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Paper hanger

10B. KIND OF BUSINESS OR
INDUSTRY

self.

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Anthony

14. MOTHER'S MAIDEN NAME

Carie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Mary Anthony 100. N. Bruce St

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Carcinoma of stomach
& metastases to lungs.INTERVAL BETWEEN
ONSET AND DEATH

approx 1 1/2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/29/49, 19, to 8/22, 1950, that I last saw the
deceased alive on Aug 19, 1950, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

William J. Robinson Jr., M.D.

23B. ADDRESS

1135 W. Fennell St.

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 23 1950

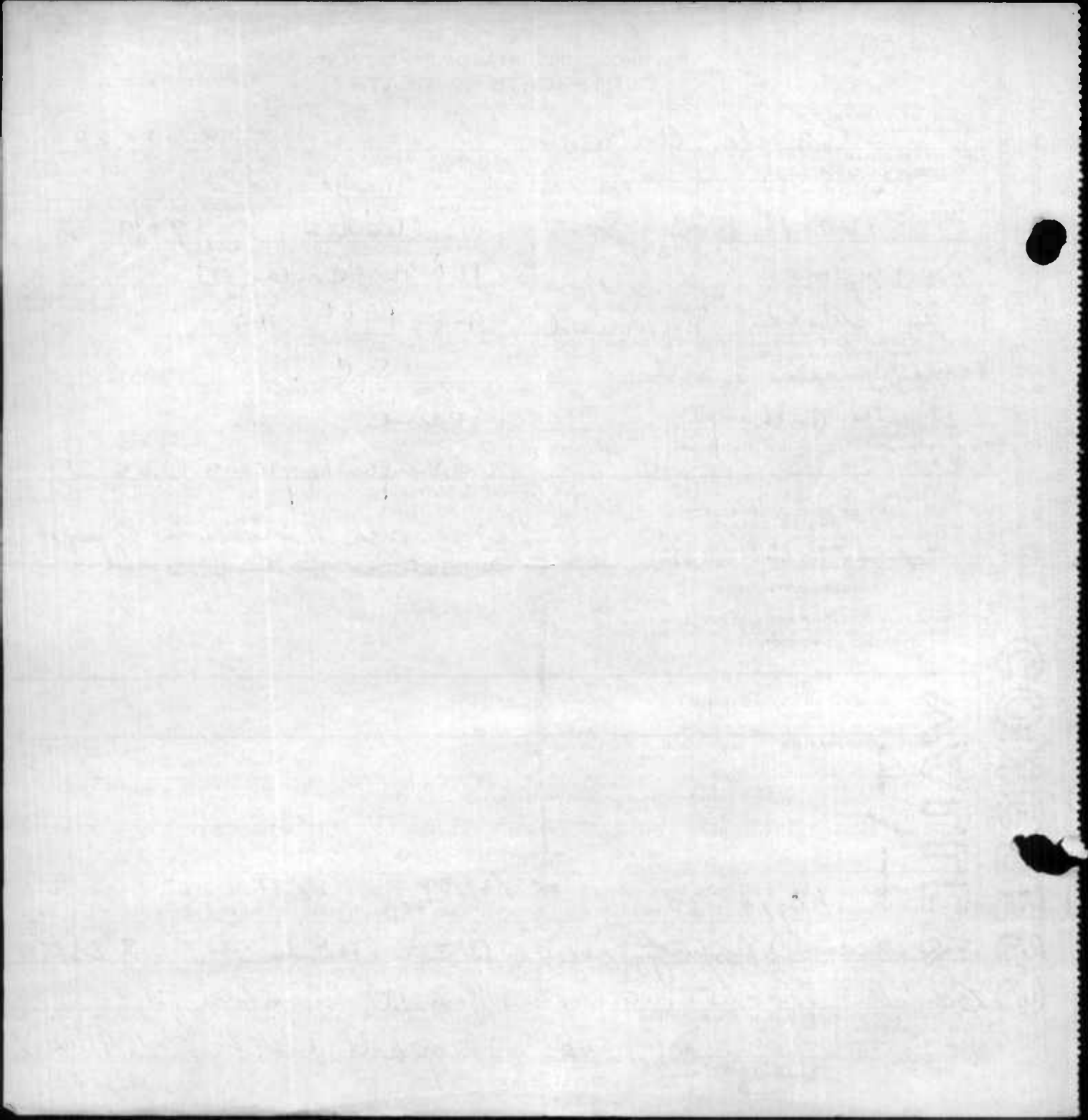
William J. Robinson Jr.

Joseph A. Sively 661 W. Barred

VS 150

56524

46B



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7292 Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RALPH W BOWLIN

2. DATE
OF
DEATH

August 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4623 Rokeby Road

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan 1, 1892

9. AGE (In years last birthday)

58

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SUPERINTENDENT

10B. KIND OF BUSINESS OR INDUSTRY

Westinghouse

11. BIRTHPLACE (State or foreign country)

Penn

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Elisha Bowlin

14. MOTHER'S MAIDEN NAME

Fredelia Hook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. MEDICAL HISTORY
Ruth A. Bowlin 4623 Rokeby Rd Baltimore 4369

18. E 903.5

CAUSE OF DEATH Ruth A. Bowlin

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive arteriosclerotic cardiovascular disease with coronary occlusion and myocardial infarct

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Skull fracture
(C) Subdural hemorrhage, minimal

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Epilepsy and chronic alcoholism

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Alley

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Alley behind 4623 Rokeby Road

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY
August 21, 1950 11:00A

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell to ground during epileptic attack

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Louth

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

August 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24 August

24C. NAME OF CEMETERY OR CREMATORY

London park

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 23 1950

VS 151

N-803.0

Thurston Williams

2903M

Harry E. Wylke

186a

4101 Edmondson

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
INVESTIGATION OF DEATH

W



PLEASE WRITE FLUENTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7293 Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Leonard J. Stein

2. DATE
OF
DEATH

August 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

St. Joseph's Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 24, 76-16

D. STREET ADDRESS (If rural, give location)

252 S. Bouldin St.,

c. Length of stay in Baltimore

Life Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 14 - 1890

9. AGE (In years

last birthday)

60

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Skilled Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Continental Can.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Stein

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Stein

252 S. Bouldin St.

18.

150X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

August 7, 1950

19B. MAJOR FINDINGS OF OPERATION

Adenocarcinoma of proximal end of stomach.

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 4, 1950 to August 19, 1950, that I last saw the deceased alive on August 19, 1950 and that death occurred at 9:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE

W. J. J. J. J.

23B. ADDRESS

1400 N. Caroline St.

23C. DATE SIGNED

8/19/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 24 - 1950

24C. NAME OF CEMETERY OR CREMATORY

Marceland Pk.

24D. LOCATION (City, town, or county)

Taylor Ave.

(State)

md.

DATE RECEIVED BY
REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John J. Cronnelly

East 21, md.

STATE OF NEW YORK
CERTIFICATE OF DEATH

County of _____
City of _____
I, _____, Registrar of the City and County of _____, do hereby certify that _____
born _____ died _____ at _____
Cause of death _____
Signed and attested at _____ this _____ day of _____, 19____.

Registrar of the City and County of _____
Signature of Registrar _____
Notary Public for the State of New York
Signature of Notary _____

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 7294

1. NAME OF DECEASED
(Type or Print)

Raymond Mayo

2. DATE
OF
DEATH

August 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Nicht Room

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

18. 299X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Intracranial hemorrhage

BLEEDING DYSCRASIA
OF UNKNOWN ORIGIN

CERTIFICATION APPROVED BY

R. Fisher

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10:00 AM, 1950 to 1950, that I last saw the
deceased alive on 8/19/50, and that death occurred at 7:45 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Periosteal proliferation

Check :- If autopsy
showed anything further?

Examination of the material

showed the following

in the material

54066-13

to the material

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7295
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT HARPER DOBSON

2. DATE
OF
DEATH

August 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION US Marine Hospital

Wyman Pk. Drive & 31st St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 6-05

D. STREET ADDRESS (If rural, give location)

422 N. Broadway

c. Length of stay in Baltimore ?

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

12/12/98

9. AGE (In years
last birthday)

51

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

orderly

10B. KIND OF BUSINESS OR
INDUSTRY

Johns Hopkins Hospital

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?

?

13. FATHER'S NAME

Wm. John Dobson

14. MOTHER'S MAIDEN NAME

Margaret Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

US Marine Corps

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18. 200.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Lymphosarcoma with involvement
of heart and kidneys

DUE TO

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 9, 1950, to Aug. 20, 1950 that I last saw the
deceased alive on Aug. 20, 1950, and that death occurred at 4:15A m., from the causes and on the date stated above.23A. SIGNATURE John L. Wilson
John L. Wilson, Medical Director M. D.23B. ADDRESS
US Marine Hospital, Balto, Md.23C. DATE SIGNED
8/22/5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150
AUG 23 1950

730PT

52a

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,
JANUARY 1, 1910.

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1909.

ALBANY:

THE STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
JANUARY 1, 1910.

ALBANY:

ALBANY:

ALBANY:

ALBANY:

ALBANY:

ALBANY:

ALBANY:

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BELLO, John Nunes

2. DATE
OF
DEATH

Aug. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Oregon

5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONU.S. Marine Hospital
Baltimore 11, MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Portland

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

Broadway Hotel

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Divorced

8. DATE OF BIRTH

Feb. 9, 1887

9. AGE (In years
last birthday)

53

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Steward

10B. KIND OF BUSINESS OR
INDUSTRY

Seafaring

11. BIRTHPLACE (State or foreign country)

Mass.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Bello

14. MOTHER'S MAIDEN NAME

Mary da Silva

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records U.S. Marine Hospital, Balto., Md

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Hemorrhage, pulmonary, due to
carcinoma of left lungINTERVAL BETWEEN
ONSET AND DEATH

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 4, 1950, to Aug. 17, 1950 that I last saw the
deceased alive on Aug. 17, 1950 and that death occurred at 2:10 A. M., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director M. D.

23B. ADDRESS

U.S. Marine Hospital, Balto., Md.

23C. DATE SIGNED

8/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

AUG 23 1950

Huntington Williams, Jr.

764 55

403-E. 25th St.

477

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "IN WITNESS WHEREOF" and "GIVEN UNDER MY HAND AND SEAL" are faintly visible.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7297
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM DENTON MASETH

2. DATE
OF
DEATH

Aug. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Continental Can Co.

Boston & Linwood Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

300 E. North Avenue

c. Length of stay in Baltimore

Life

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 5, 1896

9. AGE (In years last birthday)

54

If Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Continental Can Co. Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Maseth

14. MOTHER'S MAIDEN NAME

Louisa Willey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

WWI

16. SOCIAL SECURITY NO.

214-03-2036

17. INFORMANT 300 E. North Avenue

Mrs. Mattie M. Maseth

18. 4/20/1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

Immediate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Coronary Sclerosis
Chr. myocarditis

Indefinite

(C)

Indefinite

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 9, 1946 to Aug 21, 1950, that I last saw the deceased alive on July 10, 1950, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Nathaniel M. Beck MD

M. D.

23B. ADDRESS

1005 23rd St + Ba Ht 18 md

23C. DATE SIGNED

Aug 22 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

HENRY SANDER & SONS, INC. ADDRESS

BALTO. 13, MD. Seay P. Sander.

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7298
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

HENRY A. BURCK

2. DATE
OF
DEATH

Aug. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

26-03

D. STREET ADDRESS (If rural, give location)

3416 kentucky Avenue

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

00 3416 Kentucky Avenue

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 17, 1868

9. AGE (In years last birthday)

82

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpet layer

10B. KIND OF BUSINESS OR INDUSTRY

McDowell Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Burck

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT **3416 kentucky Avenue**

Mrs. Mary Burck

1B.

4 yr. 1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Chronic myocarditis

1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(had cerebral hemorrhage)

6 mo.

(C)

arteriosclerosis

5 yr.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **July**, 19**49**, to **Aug.**, 19**50**, that I last saw the deceased alive on **8-19**, 19**50**, and that death occurred at **2 A.** m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. J. M. Moore

M. D.

23B. ADDRESS

3105 Belair Rd

23C. DATE SIGNED

8-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

HENRY SANDER & SONS, INC. ADDRESS

BALTO., MD.

George T. Sander

937

AUG 23 1950

William H. Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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RECEIVED

CERTIFICATE CORRECTED

8-23-50

JL- 140781

7299

BALTIMORE CITY HEALTH DEPARTMENT

50

7299

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED *Ulyses*
(Type or Print) *Julius, Ivan Warren*2. DATE
OF
DEATH *8-22-50*3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE *Md.* B. COUNTY before admission)B. FULL NAME OF
HOSPITAL OR
INSTITUTION *Baltimore City Hospital*
*4940 Eastern Ave.*C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township) *Baltimore* *15-02*c. Length of stay in Baltimore *Life*
Yrs. Mos. DaysD. STREET ADDRESS (If rural, give location)
1330 N. Mount St.

5. SEX

Male

6. COLOR OR RACE

*Negro*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

*Nov. 4, 1907*9. AGE (in years
last birthday) *42*H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Waiter*10B. KIND OF BUSINESS OR
INDUSTRY *Hotel*

11. BIRTHPLACE (State or foreign country)

*Md.*12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ivan Warren

14. MOTHER'S MAIDEN NAME

*Anna Bryant*15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
*212-18-2916*17. INFORMANT ADDRESS
B. C. H. Records, 4940 Eastern Ave.

| | | | | |
|---|---|----------------|-------------|-------------------------------------|
| MEDICAL CERTIFICATION | 1B. <i>002X</i> | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | <i>2 Mos. plu plus</i> |
| | (A) <i>Pulmonary Tuberculosis</i> DUE TO | | | |
| | ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (B) DUE TO | |
| | | | (C) AT WORK | |
| II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-18-50*, 19*50*, to *Aug. 22, 1950*, that I last saw the
deceased alive on *Aug. 22, 1950* and that death occurred at *5.20AM.*, from the causes and on the date stated above.23A. SIGNATURE *H. C. Cogan*

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

*8-23-50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)DATE RECEIVED BY
LOCAL REGISTRAR
AUG 23 1950

24B. DATE

8-25-50

24C. NAME OF CEMETERY OR CREMATORY

St. Asburm Cemetery Balto., Md.

24D. LOCATION (City, town, or county)

(State)

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Charles R. Law - 802 Madison Ave.

ADDRESS

Hotel Victoria

二、三、五

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7300

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Stanley J. Tautkus

2. DATE
OF
DEATH

8*22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 885 W. Lombard

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 18-03

D. STREET ADDRESS (If rural, give location)

885 W. Lombard

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

March 27, 1902

9. AGE (In years
last birthday)

48

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
Carpenter10B. KIND OF BUSINESS OR
INDUSTRY
Shipyards

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John J.

14. MOTHER'S MAIDEN NAME

Petronia Seletski

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
217-03-9344

17. INFORMANT

ADDRESS

Miss Marie E. Tautkus 885 W. Lombard

18.

CAUSE OF DEATH.

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/8 10:30 to 8/22 50, that I last saw the
deceased alive on 8/22, 1950, and that death occurred at 5:45 pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

8-25-50

24C. NAME OF CEMETERY OR CREMATORY

Most Holy Redeemer

24D. LOCATION (City, town, or county)

4430 Belair rd.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 23 1950
VS 150

John J. Cowan & Son 901 Hollins

5103U

131a

100

Handwritten text, possibly a signature or name, located in the middle-left section of the page.

Handwritten text, possibly a signature or name, located in the bottom-left section of the page.

Handwritten text, possibly a signature or name, located in the bottom-right section of the page.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7301
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT JAMES ROBINSON

2. DATE
OF
DEATH

August 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1507 Lemon Street

C. Length of stay in Baltimore Life

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/6/1930

9. AGE (In years last birthday)

19

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Helper

10B. KIND OF BUSINESS OR INDUSTRY

Ice

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Robinson

14. MOTHER'S MAIDEN NAME

Leah Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Leah Johnson 1507 Lemon St

18. 430.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

Myocardial infarct

ANTECEDENT CAUSES

(B) Aneurysm of left ventricle with rupture

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Hemopericardium

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William L. Smith

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D.

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/24/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William L. Smith

25. FUNERAL DIRECTOR

ADDRESS

Elroy O. Wilson, 1000 Bantley

V S 151

9706T

94a

STATE OF NEW YORK

IN SENATE

January 1, 1901

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

THE STATE PRINTING OFFICE

1901

Price, 50 CENTS

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Insurance, 10 CENTS

Storage, 10 CENTS

Handling, 10 CENTS

Delivery, 10 CENTS

Receipt, 10 CENTS

Return, 10 CENTS

Exchange, 10 CENTS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7302
Registered No.

BIRTH NO. 50 7302

| | | | |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) William E. Billmire | | 2. DATE OF DEATH Aug. 21, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 3401 Walbrook Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION DO | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-06 | |
| c. Length of stay in Baltimore 74 Years Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 3401 Walbrook Ave. | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 4, 1876 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY B. & O R R | 9. AGE (In years last birthday) 74 If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min. |
| 13. FATHER'S NAME John E. Billmire | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME Fannie E. Cooke | |
| 17. INFORMANT | | ADDRESS Mrs. E. Gertrude Billmire 3401 Walbrook Ave | |

18. **420.1**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **Coronary thrombosis**
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
about 3 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Arterio-sclerosis**
DUE TO

?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

| | | | | | |
|--|--|--|--|--|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug 2 , 19 50 , to Aug 21 , 19 50 that I last saw the deceased alive on Aug 21 , 19 50 , and that death occurred at 5 P.m. , from the causes and on the date stated above. | | | | | |

| | | |
|--|---|--------------------------------------|
| 23A. SIGNATURE William E. Billmire | 23B. ADDRESS M. D. 2220 Garrison Blvd | 23C. DATE SIGNED Aug 23/50 |
|--|---|--------------------------------------|

| | | | |
|--|-----------------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 24, 1950 | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 24D. LOCATION (City, town, or county) (State) Woodlawn Md. |
| DATE RECEIVED BY LOCAL REGISTRAR | | 25. FUNERAL DIRECTOR George B. Meyer Jr. ADDRESS 1512 Hollins St. | |

AUG 23 1950

William E. Billmire, M.D.
39050

Baltimore 23 Md. 94a

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

REPORT OF THE CHIEF, BUREAU OF PLANT INDUSTRY
FOR THE YEAR 1914

BY THE CHIEF, BUREAU OF PLANT INDUSTRY

AND

BY THE CHIEF, BUREAU OF PLANT INDUSTRY

AND

BY THE CHIEF, BUREAU OF PLANT INDUSTRY

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BY THE CHIEF, BUREAU OF PLANT INDUSTRY

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BY THE CHIEF, BUREAU OF PLANT INDUSTRY

AND

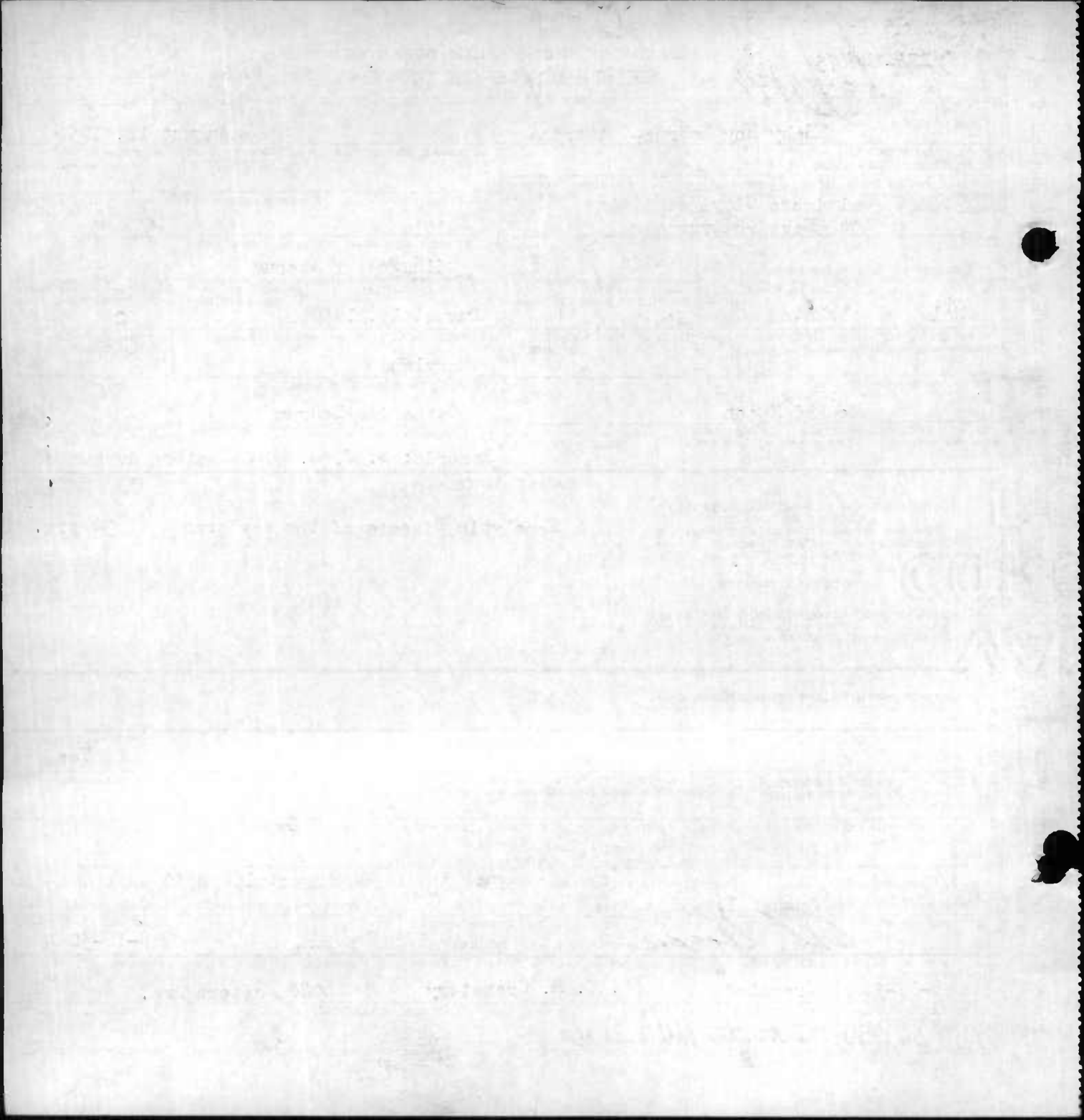
BY THE CHIEF, BUREAU OF PLANT INDUSTRY

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7308

| | | | | | |
|---|---------------------------|---|-------------------------------------|--|---|
| BIRTH NO. 50-16949 | | 1. NAME OF DECEASED (Type or Print) Baby Boy LeBrun-Catherine | | 2. DATE OF DEATH August 16, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 31 4940 Eastern Avenue | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-03 | | | |
| c. Length of stay in Baltimore Life | | D. STREET ADDRESS (If rural, give location) 2516 Foster Avenue | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH August 15, 1950 | 9. AGE (in years last birthday) 2 | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Howard Mason | | 14. MOTHER'S MAIDEN NAME Catherine LeBrun | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Records: B. C. H. 4940 Eastern Avenue | |
| 18. 770.0 I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hemolytic Disease of the newborn | | | | INTERVAL BETWEEN ONSET AND DEATH 34 yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from August 15, 1950, to August 16, 1950, that I last saw the deceased alive on August 16, 1950 and that death occurred at 3 P. M., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE B. C. H. | | 23B. ADDRESS 4940 Eastern Avenue | | 23C. DATE SIGNED 8-18-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) 8-17-50 | | 24B. DATE Cremated | | 24C. NAME OF CEMETERY OR CREMATORY B. C. H. Crematory | |
| 24D. LOCATION (City, town, or county) 4940 Eastern Ave. | | 24E. LOCATION (City, town, or county) (State) | | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 24 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-16840

1. NAME OF DECEASED
(Type or Print)

WILSON, ELIZABETH (BABY)

2. DATE
OF
DEATH

Aug 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, or institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
BALTIMORE township)

D. STREET ADDRESS (If rural, give location)

1519 N. BROADWAY

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8-11-50

9. AGE (in years
last birthday)If Under 1 Year
Months: Days

6

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Elijah Wilson

14. MOTHER'S MAIDEN NAME

Elizabeth Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 760.5 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) INTRACRANIAL HEMORRHAGE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) PREMATURITY

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-11, 1950, to 8-16, 1950, that I last saw the
deceased alive on 8-16, 1950, and that death occurred at 3:45 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Henry M. Serdel

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 24 1950

Huntington Williams, M.D.

7 3 0 3

U.S.A.

BALTIMORE, MD.

12-1-71

INTERNAL SECURITY - RACIAL

PRIORITY

Hand to [illegible]

PLEASE WRITE MAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7305

BIRTH No. 50-16482

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Baby Boy Aquilla 397431 | | 2. DATE OF DEATH AUG 16 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 7-04 | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL | | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| 7. STREET ADDRESS (If rural, give location) 1037 Rutland Ave | | 8. DATE OF BIRTH 8-6-50 | |
| 9. AGE (In years last birthday) 10 | | 10. CITIZEN OF WHAT COUNTRY? 10 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? PAULINE | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT JOHNS HOPKINS HOSPITAL | | ADDRESS | |
| 18. 768.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Septicemia of Newborn DUE TO not known | | INTERVAL BETWEEN ONSET AND DEATH 218 hours | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Possible birth injury to brain | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 8-6-1950 to 8-16-1950 , that I last saw the deceased alive on 8-16-1950 and that death occurred at 105 A.m. , from the causes and on the date stated above. | | | |
| 23A. SIGNATURE Edward Wisler Hopkins M.D. | | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | |
| 23C. DATE SIGNED 8-16-50 | | 24A. BURIAL, CREMATION, REMOVAL (Specify) | |
| 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY Forest Home | |
| 24D. LOCATION (City, town, or county) (State) | | 25. FUNERAL DIRECTOR | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 24 1950 | | REGISTRAR'S SIGNATURE Wilmington Williams, M.D. | |
| VS 150 | | Hospital disposal | |

160a

218

Sept 20 1902

NOT AROUND

Possible birth in July 1902

2-10-00

2nd child

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 7306

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROSE FEDDER

2. DATE
OF
DEATH

8/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

SINAI HOSPITAL

D. STREET ADDRESS (If rural, give location)

2228 Madison Ave.

c. Length of stay in Baltimore

40

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

9. AGE (In years
last birthday)

60

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

New Acervity

14. MOTHER'S MAIDEN NAME

Rae

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Harry Fedder - 2228 Madison Ave

18.

241X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Bronchial Asthma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 10, 1950, to Aug 23, 1950, that I last saw the
deceased alive on Aug 23, 1950, and that death occurred at 4:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

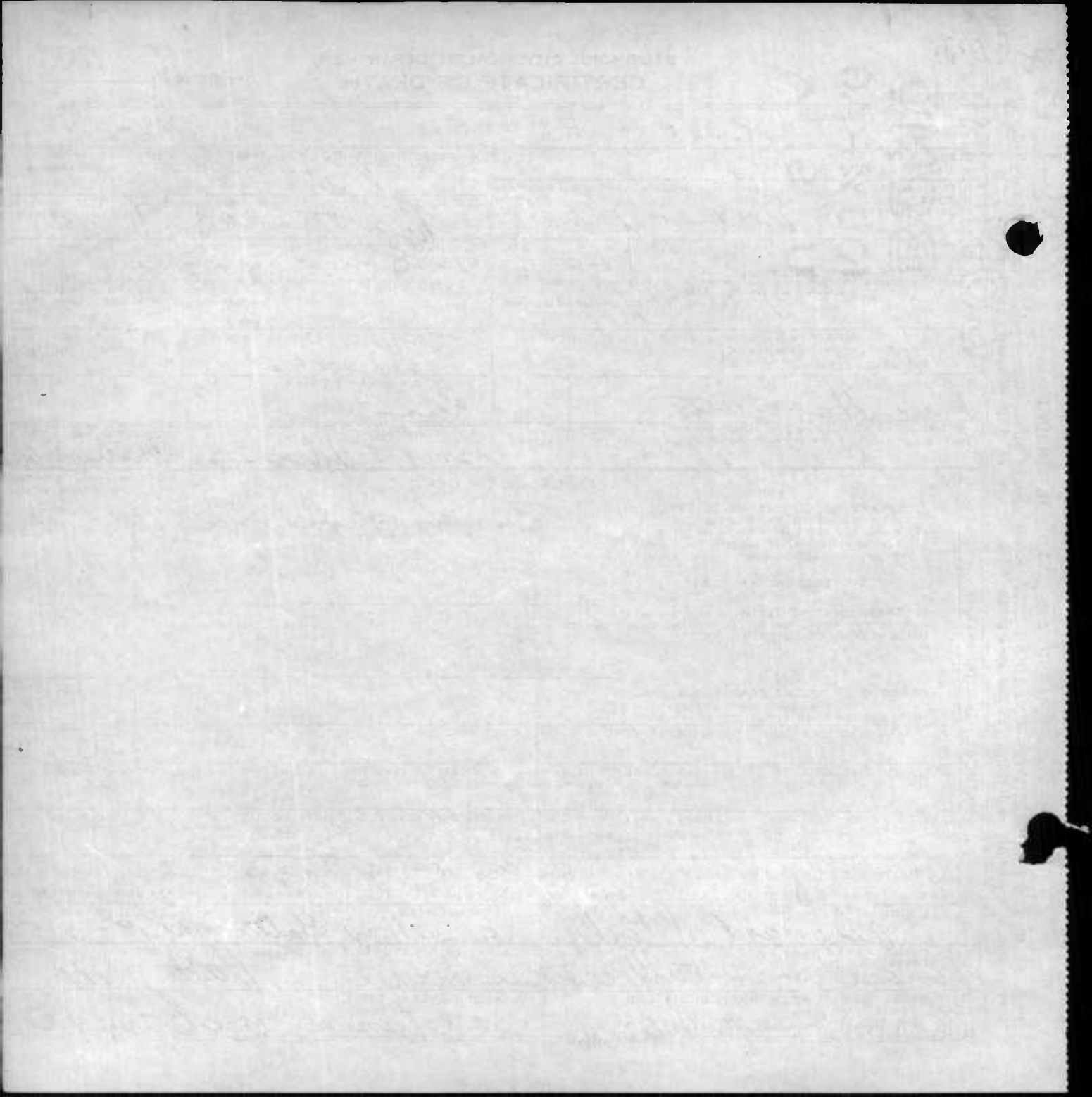
25. FUNERAL DIRECTOR

ADDRESS

AUG 24 1950

Huntington Williams, M.D.

Jack Lewicki 2100 Eutaw Pl



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7307
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

EDNA R. MICHEL

2. DATE
OF
DEATH

8/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

SINAI

HOSPITAL

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write R.I., L. and give township)

D. STREET ADDRESS (If rural, give location)

2406

Callow

Av.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (In years last birthday)

64

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Martinsburg W. Va.

13. FATHER'S NAME

Robert R.

14. MOTHER'S MAIDEN NAME

Bena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Robert Michel

ADDRESS

2406 Callow Av.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Metastatic MALIGNANT
DUE TO MELANOMA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Removal of inguinal node

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

Removal of melanoma from sole of foot

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/16/50, 1950, to 8/23, 1950, that I last saw the deceased alive on 8/23, 1950, and that death occurred at 8:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Alvin B. Abramson

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-25-50

24C. NAME OF CEMETERY OR CREMATORY

Shel Holom

24D. LOCATION (City, town, or county)

Balto, Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 24 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Cutaw Pl

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

IN RE: THE ESTATE OF JAMES M. SMITH, DECEASED

JOHN A. SMITH, Executor

vs.

JOHN A. SMITH, Defendant

JOHN A. SMITH, Plaintiff

JOHN A. SMITH, Defendant

JOHN A. SMITH, Plaintiff

JOHN A. SMITH, Defendant

JOHN A. SMITH, Plaintiff

JOHN A. SMITH, Defendant

JOHN A. SMITH, Plaintiff

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7308

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Philip Johnson

2. DATE
OF
DEATH

8/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Bar-Wil-Ba Convalescent Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1235 E. Madison St.

c. Length of stay in Baltimore

60 yrs

5. SEX

Male

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Unknown

9. AGE (In years
last birthday)

75

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington DC

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

William Russell 219 Duquesne Ct

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Cardiovascular Disease

(B)

DUE TO

Terminal Pneumonia

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

1 yr.

1 yr.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 20, 1950, to Aug 21, 1950, that I last saw the
deceased alive on 8/20, 1950, and that death occurred at 9:35 a.m. from the causes and on the date stated above.

23A. SIGNATURE

Philip Johnson M.D.

23B. ADDRESS

403 Madison St. Bg

23C. DATE SIGNED

8/21/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8/24/50

Mt. Auburn

Baltimore

M.D.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 24 1950

Hattie Snow

1408 Ashland Ave.

CERTIFICATE OF DEATH

THE STATE OF TEXAS, COUNTY OF DALLAS

1900

2

DATE

TIME

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS IN THE COUNTY OF DALLAS, TEXAS.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 7309**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Miriam Sherman

2. DATE
OF
DEATH

Aug 23, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

modest ave

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

Md

B. COUNTY

b. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-16

d. STREET ADDRESS (If rural, give location)

2803 Urban ave

c. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH

9-28-21

9. AGE (in years last birthday)

28

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Morris Zafren

14. MOTHER'S MAIDEN NAME

Sadie Edsall

50-17097

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. *687 x 1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebrovascular Accident,*

DUE TO *exact nature not known,*

(B) *possibly cerebral veins*

DUE TO *thrombosis - post partum*

(C) *9 days.*

INTERVAL BETWEEN ONSET AND DEATH

5 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-14-*, 19*50* to *8-23-*, 19*50* that I last saw the deceased alive on *8-23-*, 19*50* and that death occurred at *10:45 AM*, from the causes and on the date stated above.

23a. SIGNATURE

Robert M. Paine, D.

23b. ADDRESS

JOHNS HOPKINS HOSPITAL

23c. DATE SIGNED

9/23/50

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

Aug. 24, 1950

24c. NAME OF CEMETERY OR CREMATORY

Bnai Israel Congregation

24d. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

AUG 24 1950

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

Sol. Levinson & Bros. W. North Ave.

VS 150

147-c

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Dams said

probable outcome of com on
material deaths discussion

and ~~the~~ central incident

(not material) However he
wants copy of this for committee

as is. EA 8.30.50

Birth - 50-17097 - 8/14/50

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANCES C. HARRISON

2. DATE
OF
DEATH

8-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION

938 E. Biddle St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

938 E Biddle St.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

7-31-1873

9. AGE (In years last birthday)

77

If Under 1 Year Months Days Hours Min.

0 23

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

2

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Kelly

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Edna Spignataro

ADDRESS

938 E. Biddle

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pyelonephritis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized Cerebral sclerosis

unknown

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 18, 1950, to August 23, 1950, that I last saw the deceased alive on August 24, 1950, and that death occurred at 3:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

James J. Hoban

M. D.

23B. ADDRESS

5804 Edmondson A, Balt 28 Md

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-26-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery Baltimore Md

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 24 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, Jr.

25. FUNERAL DIRECTOR

Charles W. Conklin

ADDRESS

924 E. Eager

Mr. James Nolan
4903 Stafford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7311

BIRTH NO. 50-17627

1. NAME OF DECEASED
(Type or Print)

BABY BOY DeKENIS

2. DATE
OF
DEATH

8/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hosp. of Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt.

4-02

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

649 W. Lombard St.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

8/22/50

9. AGE (In years
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

3

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Albert Dekenis

14. MOTHER'S MAIDEN NAME

Anna Martinikus

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Algard Dekenis

18. 754.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Congenital heart - incompatible

DUE TO

Life

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

Hydrocephalus

Spina bifida

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/22/50, 1950, to 8/22, 1950, that I last saw the
deceased alive on 8/20, 1950, and that death occurred at 4:01 p.m., from the causes and on the date stated above.

23A. SIGNATURE

James L. Gray

23B. ADDRESS

Lutheran Hosp. of Md.

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 24 1950

VS 150

157a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1911

1911

1911

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1911

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7312

Registered No. _____

BIRTH NO. _____

| | | | |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Lillie May Fritz</i> | | 2. DATE OF DEATH <i>8/22/50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY _____ | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <i>2856 Rayner Ave</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | D. STREET ADDRESS (If rural, give location) <i>2856 Rayner Ave</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>2/16/1887</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | 9. AGE (In years last birthday) <i>63</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? _____ | |
| 13. FATHER'S NAME <i>Columbus R. Ritter</i> | | 14. MOTHER'S MAIDEN NAME <i>Malinda Moore</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>111-111111</i> | |
| 17. INFORMANT <i>Leo Wiegand</i> | | ADDRESS <i>2856 Rayner Ave</i> | |

| | | |
|---|---|--|
| 18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH (A) <i>Hypertensive - Cardio - vascular disease with auricular fibrillation</i> DUE TO _____ (B) _____ DUE TO <i>Hypertension</i> (C) _____ | INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>years?</i> |
| | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. | |
| | 19A. DATE OF OPERATION <i>none</i> 19B. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | | | |
|--|--|--|--|--|--|
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |

22. I hereby certify that I attended the deceased from _____, 19____, to *Aug 22*, 19*50*, that I last saw the deceased alive on *Aug 22*, 19*50*, and that death occurred at *11:05 A.m.*, from the causes and on the date stated above.

| | | |
|--|---|--------------------------------------|
| 23A. SIGNATURE <i>William J. Sullivan</i> | 23B. ADDRESS <i>2911 Harrison Blvd</i> | 23C. DATE SIGNED <i>aug 24-50</i> |
|--|---|--------------------------------------|

| | | | |
|--|-----------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>8/26/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i> | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> |
|--|-----------------------------|--|--|

| | | | |
|--|---|---|-------------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 24 1950</i> | REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>Wm Cook Inc.</i> | ADDRESS <i>1217 St. Paul St.</i> |
|--|---|---|-------------------------------------|

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED

9-7-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7313

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PHILIP WILLIAMS HOWARD

2. DATE
OF
DEATH

August 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR US Marine Hospital
INSTITUTION

Wyman Pk. Drive & 31st St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 27-12

C. Length of stay in Baltimore

?

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

321 Broadmoor Road

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12/22/03

9. AGE (In years
last birthday)

46

11 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Fin. Ass't Secty. Treas.

10B. KIND OF BUSINESS OR
INDUSTRY

New Amsterdam Ins. Co.

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

William T. Howard

14. MOTHER'S MAIDEN NAME

Mary Cushing Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18. 201X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkins Disease of
mediastinum, heart & lungsat least
10 mos
duration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID. (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 7, 1950, to Aug. 22, 1950, that I last saw the deceased alive on Aug. 22, 1950, and that death occurred at 1 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Frank London m.p.

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

8/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Green Mount

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY REGISTRAR'S SIGNATURE

LOCAL REGISTRAR

AUG 24 1950

25. FUNERAL DIRECTOR

ADDRESS

1214 S Paul St

STATE OF NEW YORK
DEPARTMENT OF HEALTH

IN SENATE
January 1, 1914

REPORT OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR 1913

ALBANY:
J. B. LIPPINCOTT COMPANY
1914

PRINTED BY THE
STATE OF NEW YORK
PRINTING OFFICE

ALBANY:
J. B. LIPPINCOTT COMPANY
1914

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J. B. LIPPINCOTT COMPANY
1914

ALBANY:
J. B. LIPPINCOTT COMPANY
1914

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

350 50 7314
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT WINFIELD SCAGGS, Sr.

2. DATE
OF
DEATH

August 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1809 Wilhelm St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

June 24, 1892

9. AGE (In years last birthday)

58

10 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Cabinet maker
Montgomery Ward

11. BIRTHPLACE (State or foreign country)

Laurel, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James A. Scaggs, Sr.

14. MOTHER'S MAIDEN NAME

Annie E. Beall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT
Laurel, Maryland
Robert W. Scaggs, Jr. 35 Fourth St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) ...Crushing injury of chest...

DUE TO

ANTECEDENT CAUSES

(B) ...Multiple bruises, lacerations and contusions...

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) ...

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Blvd.

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2200 block Washington Blvd.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 21, 1950 6:15

21E. INJURY OCCURRED

a. WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into electric pole

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Dunleavy

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

August 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 24 1950

Washington Williams, Jr.

W. W. Donaldson, Laurel, Md.

V S 151

5106C

170C

U. S.

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO THE SECRETARY OF THE INTERIOR
WASHINGTON, D. C.

FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SALT LAKE CITY, UTAH

SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to a specific area or project. Key words that are faintly visible include "land", "management", "survey", "report", and "recommendations".]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7315

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Pius T. Shue

2. DATE
OF
DEATH

Wed. Aug. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1526 S. Charles St.

C. CITY OR TOWN

(If outside corporate limits, write both (A) and give township)

Baltimore

23-02

C. Length of stay in Baltimore

About 45 yrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Oct. 5, 1879

9. AGE (In years

last birthday)

70

H Under 1 Year

Months: Days

I Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Locomotive Engineer - B. & O. R. R.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

York, Pa.

12. CITIZEN OF

WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Zachara Shue -

14. MOTHER'S MAIDEN NAME

Emilie Tracey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

705-10-0815

17. INFORMANT

Mrs. Elizabeth C. Shue (Wife)

ADDRESS

Same

18.

002X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Pulmonary Tuberculosis
Bi-lateral

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, 19, to 8/23/1950, that I last saw the deceased alive on 8/21/50, 19, and that death occurred at 4:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Dennis J. McLaughlin

23B. ADDRESS

11 E. Randall St.

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Sat. Aug. 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

London Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 24 1950

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

G. Boward Evans

ADDRESS

1400 S. Charles St. Balto. 30, Md. 13B

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

IN SENATE
JANUARY 1, 1900

REPORT OF THE
COMMISSIONER OF HEALTH

FOR THE YEAR 1899

ALBANY, N. Y.:
JANUARY 1, 1900.

PRINTED BY
THE STATE PRINTING OFFICE

ALBANY, N. Y.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7316

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM A. (FUNK) FUNKE

2. DATE
OF
DEATH

August 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2705 Orleans Street

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 27, 1898

9. AGE (In years last birthday)

(51)

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Police

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.,

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Funke

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Myrtle Funke 2705 Orleans St.,

18. E976 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Internal hemorrhage due to bullet wound of chest

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2705 Orleans Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 22, 1950 8:40 a.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in chest

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Dinsdale, M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

August 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Colgate, Md

(State)

DATE RECEIVED BY LOCAL HEALTH DEPARTMENT

AUG 24 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 20 8 Orleans St.,

V S 151

N-862.4

773 30

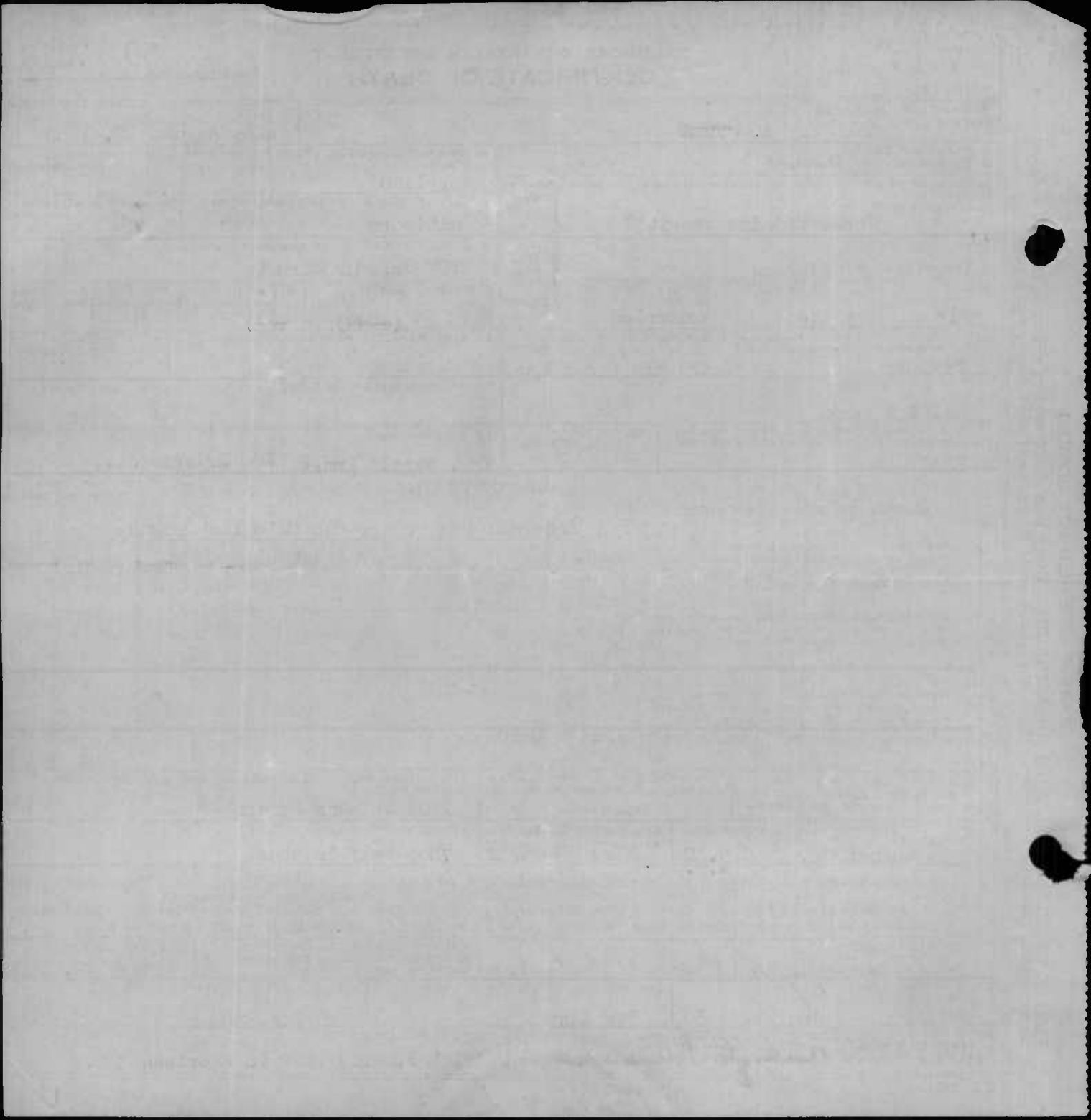
1642

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7317

| | | | | | |
|---|---------------------------|---|-----------------------------------|---|-------------------------------|
| BIRTH NO. <u>50 7317</u> | | 1. NAME OF DECEASED (Type or Print) <u>LASSITER, GEORGE</u> | | 2. DATE OF DEATH <u>8/21/50</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto. Md.</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Balto.</u> B. COUNTY <u>Md.</u> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Franklin Square Hospital</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Md.</u> <u>19-02</u> | | | |
| c. Length of stay in Baltimore Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u> | | D. STREET ADDRESS (If rural, give location) <u>234 N. Stricker St.</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>9/19/1913</u> | 9. AGE (In years last birth day) <u>36</u> | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | | 11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | 13. FATHER'S NAME <u>Marcellus Lassiter</u> | | 14. MOTHER'S MAIDEN NAME <u>Mamie Dickens</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Franklin Square</u> | |
| 18. <u>574X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Septicemia</u> DUE TO (B) <u>Pelvic-rectal abscess</u> DUE TO (C) <u>FISTULA IN ANO</u> INTERVAL BETWEEN ONSET AND DEATH <u>(None)</u> | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>8/18/50</u> | | 19B. MAJOR FINDINGS OF OPERATION <u>Pelvic-rectal abscess.</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>8-18</u> , 19 <u>50</u> to <u>8/21</u> , 19 <u>50</u> that I last saw the deceased alive on <u>8/21</u> , 19 <u>50</u> , and that death occurred at <u>6.45 A.</u> m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>Edward W. Lamberbach</u> M. D. | | 23B. ADDRESS <u>Franklin Square</u> | | 23C. DATE SIGNED <u>8/21/50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-24-1950</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>W. Auburn Cem. Balto.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Md.</u> | | 24E. FUNERAL DIRECTOR <u>Mrs. Violet P. Williams</u> | | 24F. ADDRESS <u>322 N. Howard St.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 24 1950</u> | | REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u> | | VS 150 | |

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Did the operations for the
disclosure, cause
underlying the pello-rectal abscess?

See Document File 50-7317

7 5 50 Es

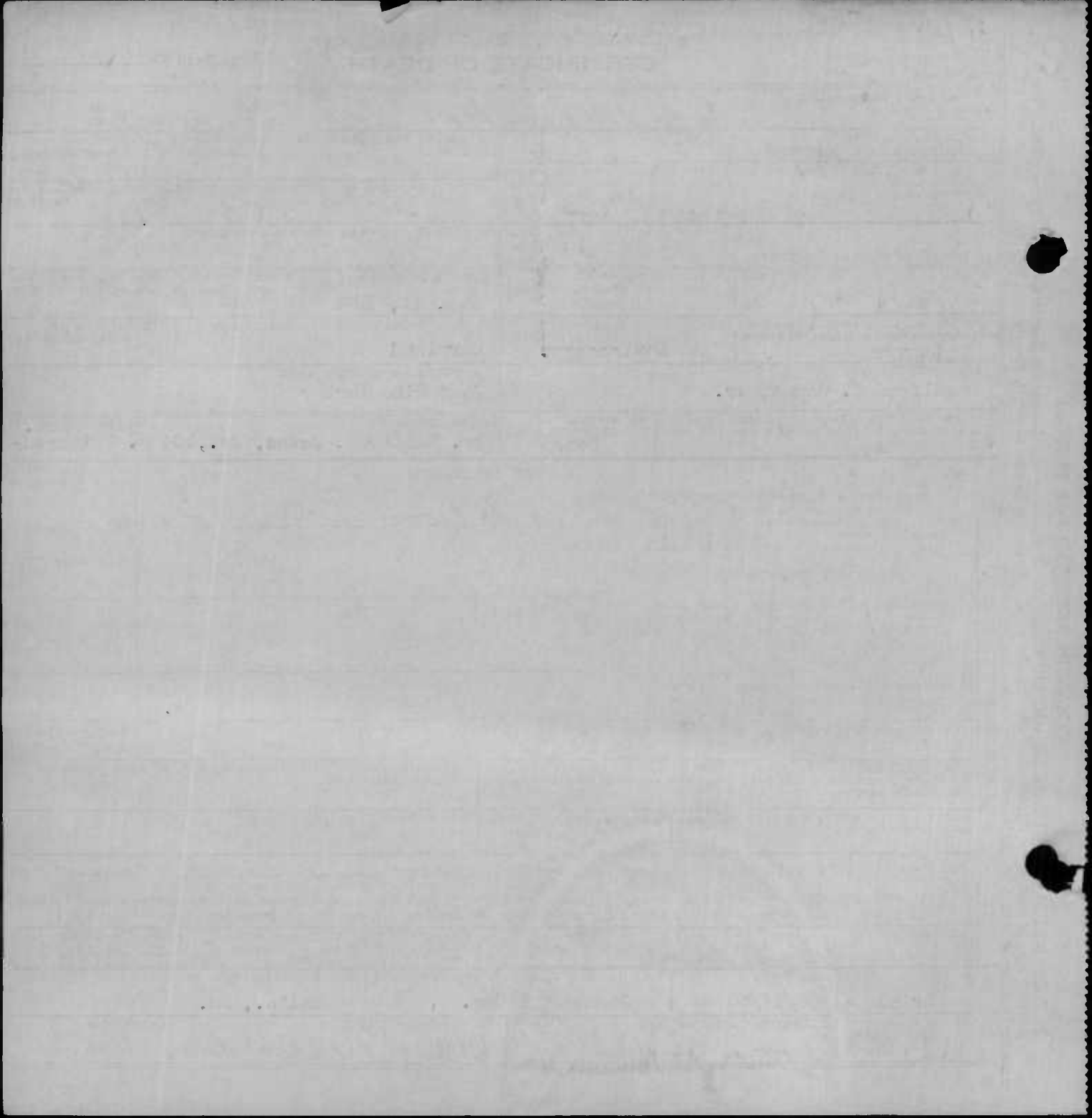
PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

 Registered No. **50 7318**

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) <i>Alfred Thomas Jones Jr</i> | | 2. DATE OF DEATH <i>8/23/50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <i>320 E. University Pkwy</i> | | C. CITY OR TOWN (If outside corporate limits, write full name and give township) <i>Sc 1 to 11</i> | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) <i>320 E. University Pkwy</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i> | 8. DATE OF BIRTH <i>Feb. 13, 1872</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Law</i> | 9. AGE (In years last birthday) Months Days <i>78</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Alfred T. Jones, Sr.</i> | | 14. MOTHER'S MAIDEN NAME <i>Josephine Parker</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | |
| 17. INFORMANT <i>Mr. Walter H. Jones, Jr., 104 W. Universi-</i> | | ADDRESS <i>ty Pkwy.</i> | |
| 18. <i>422.1</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Asperose hae RV D</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | |
| 23A. SIGNATURE <i>Wm. J. Sickner</i> | | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR | |
| 23C. DATE SIGNED <i>8/23/50</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>8/26/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cem.</i> | 24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 24 1950</i> | | REGISTRAR'S SIGNATURE <i>Wm. J. Sickner</i> | |
| 25. FUNERAL DIRECTOR <i>Wm. J. Sickner</i> | | ADDRESS <i>Balto.</i> | |



MARGIN RESERVED FOR BINDING

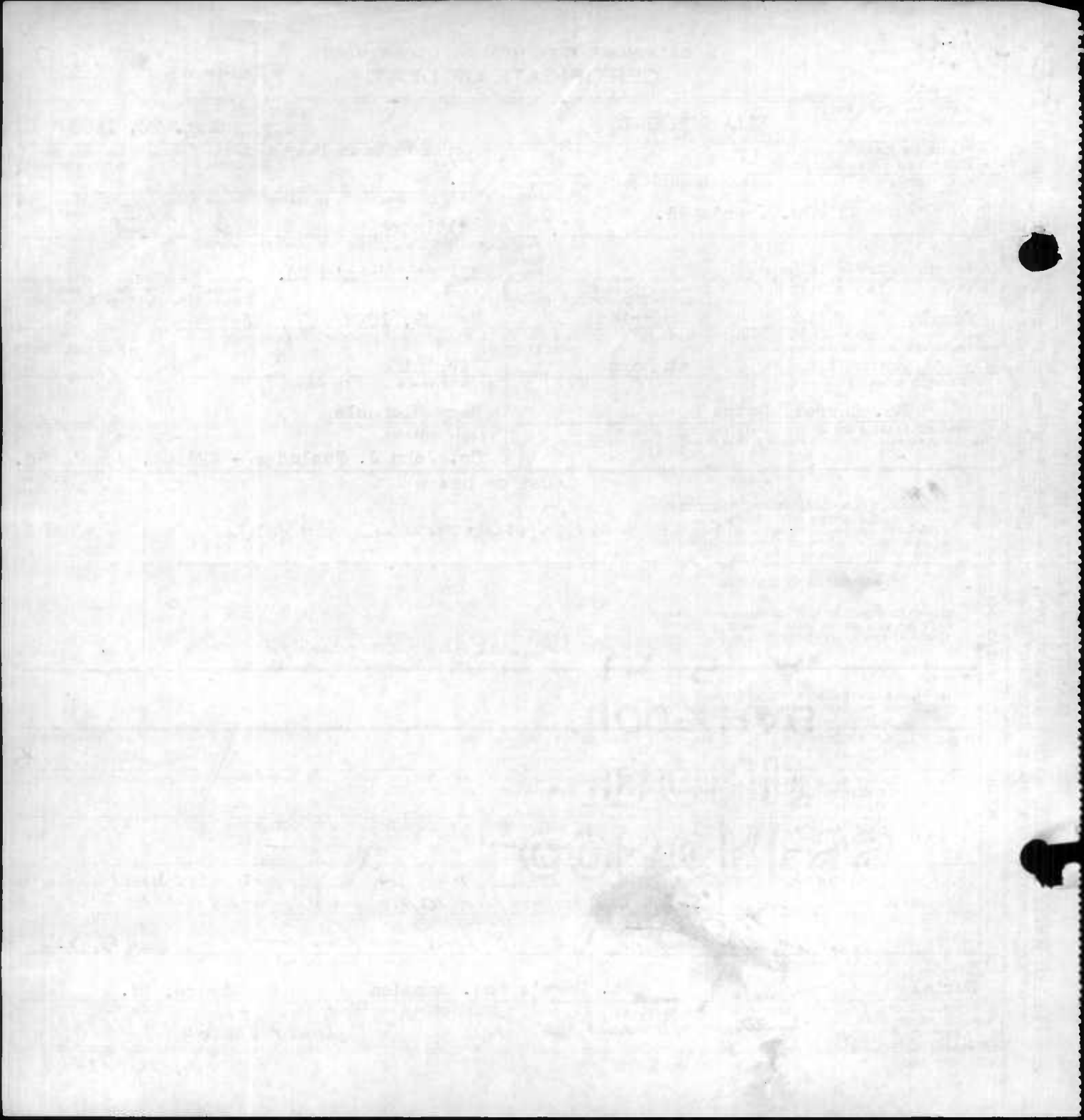
PLEASE WRITE ONLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7319

| | | | | | |
|---|----------------------------------|---|---|---|--|
| BIRTH NO. <u>80 7319</u> | | 1. NAME OF DECEASED (Type or Print) <u>ELLA RUTLEDGE</u> | | 2. DATE OF DEATH <u>Aug. 22, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>621 St. John's Rd.</u> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>27-13</u> | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) <u>621 St. John's Rd.</u> | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>May 29, 1862</u> | 9. AGE (In years last birthday) <u>88</u> | If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? _____ |
| 13. FATHER'S NAME <u>Wm. Carroll Gates</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Michaels</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT ADDRESS <u>Dr. John J. Rutledge - 621 St. John's Rd.</u> | | |
| 18. <u>4221 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>(A) Arteriosclerotic C-V-D</u> DUE TO <u>(B) _____</u> DUE TO <u>(C) Generalized Arteriosclerosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>2</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. _____ | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION _____ | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I hereby certify that I attended the deceased from <u>Aug 22, 1950</u> , to <u>Aug 22, 1950</u> that I last saw the deceased alive on <u>Aug 22, 1950</u> , and that death occurred at <u>10 P. m.</u> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>Wm. J. Lickner</u> | | 23B. ADDRESS <u>8 Longwood Road</u> | | 23C. DATE SIGNED <u>Aug 23, 1950</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/26/50</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem. Hampden</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 24 1950</u> | | REGISTRAR'S SIGNATURE <u>Wm. J. Lickner</u> | | 25. FUNERAL DIRECTOR ADDRESS <u>Wm. J. Lickner & Sons</u> | |

93D mid.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7320

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HELEN M. SULLIVAN

2. DATE
OF
DEATH

Aug. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Md.

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

4409 Wentworth Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

28-02

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

4409 Wentworth Rd.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Nov. 1892

9. AGE (In years
last birthday)

57

If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Secretary

10B. KIND OF BUSINESS OR
INDUSTRY

Banking--

11. BIRTHPLACE (State or foreign country)

-

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Sullivan

14. MOTHER'S MAIDEN NAME

Margaret Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
212-01-9939

17. INFORMANT

ADDRESS

Mrs. Margaret F. Denny -- 4409 Wentworth Ave.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Thrombosis

Immediate

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B)

(1) - Chronic Infected Gall Bladder - 6 months

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Heart. Prostating (8-2-50)

One day.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 22, 1950, to Aug. 22, 1950, that I last saw the
deceased alive on 8/21, 1950, and that death occurred at 1 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Earl L. Chambers

M. D.

23B. ADDRESS

4108 Liberty Hts. Ave.

23C. DATE SIGNED

8/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/25/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 24 1950

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Dickens & Sons - Balto

ADDRESS

VS 150

290 71

94a Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE CORRECTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Did you by placing (1)

before Chronic Infected Gall Bladder

indicate your preference of that as the
underlying cause of death?

See Document, File 50-7370
9550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7321

BIRTH NO.

| | | | | | |
|--|---------------------------|--|--|---------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) EDWARD KUTS (OR) KUTZ | | | 2. DATE OF DEATH August 22, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore LIFE Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 106 S. Ann Street | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH -1894 | 9. AGE (In years last birthday) 55 | If Under 1 Year Months Days If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR | | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JOHN KUTZ | | | 14. MOTHER'S MAIDEN NAME ANNA. BIEDRONSKA. | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 217-01-8506 | 17. INFORMANT ADDRESS HELEN KWIATKOWSKI 745 S DECKER AVE. | | |

| | | |
|--|--|----------------------------------|
| 18. <u>E90201</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Depressed skull fracture with laceration of brain Subdural hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|--|--|--|--|--|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Sidewalk | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sidewalk in front of 106 S. Ann Street | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 20, 1950 A. M. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell from third floor window to ground | |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | | |
| 23A. SIGNATURE William V. ... | | M.D. 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 23C. DATE SIGNED August 23, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE AUG 26 1950 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY | |
| 24D. LOCATION (City, town, or county) GERMAN HILL RD MD. | | 24E. DATE RECEIVED BY LOCAL REGISTRAR | | 24F. REGISTRAR'S SIGNATURE Thurston Williams | |
| 24G. FUNERAL DIRECTOR Ruppel Bros. | | 24H. ADDRESS 1800 ELMOND ST | | 24I. DATE RECEIVED BY LOCAL REGISTRAR AUG 24 1950 | |

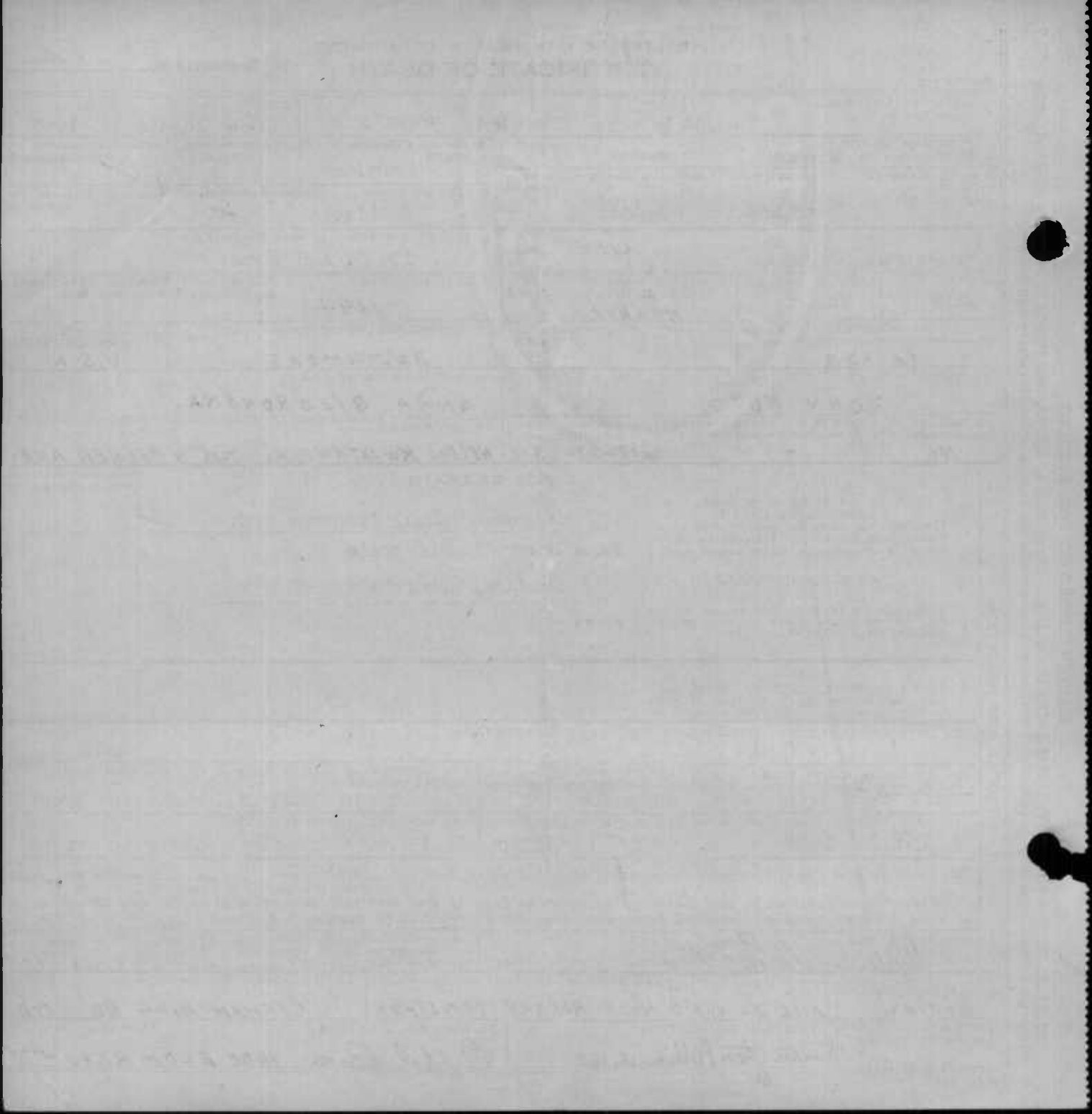
N-803

590 4G

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7322

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HENRIETTA

JOHNSON

2. DATE
OF
DEATH

August 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

833 Aisquith Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

8-10-1882

9. AGE (In years
last birthday)

68

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harrison Woods

14. MOTHER'S MAIDEN NAME

Mary P

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Preston Johnson 833 Aisquith St

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Overlander

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

8-22-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8-26-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem A. A. Co

24D. LOCATION (City, town, or county)

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 24 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Rayner Sanders

93D

1412 E. Preston St

STATE OF OHIO

IN SENATE,
 January 12, 1903.
 REPORT
 OF THE
 COMMISSIONER OF THE
 LAND OFFICE,
 IN RESPONSE TO A
 RESOLUTION PASSED
 BY THE SENATE,
 MAY 1, 1902.
 COLUMBUS, OHIO:
 THE STATE PRINTING OFFICE,
 1903.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7323

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Pearl Hainman (Hainman)

2. DATE
OF
DEATH

8-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONBaltimore City Hospitals
4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore township)

D. STREET ADDRESS (If rural, give location)

1039 Cathedral Street

c. Length of stay in Baltimore

25 yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

8-15-1889-1891?

9. AGE (in years
last birthday)

? 61-59?

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

? Pa.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease with
failure

36 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Pulmonary Congestion and edema-C.P.C.

36 hrs.
of Liver

DUE TO

(C) Hemorrhage in Sella Tursica

Unknown

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.Adrenal Cortical Tumor-Dilation of
Stomach

2 hrs.

19A. DATE OF OPERATION

8-16-50

19B. MAJOR FINDINGS OF OPERATION

Exploratory- no findings.

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., to or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-18-1933, to 8-18-1950, that I last saw the
deceased alive on 8-18-1950, and that death occurred at 1:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

J. H. Hogan

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/24/50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart Cem.

24D. LOCATION (City, town, or county)

German Hill Rd

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John J. Foley & Sons.

AUG 24 1950

VS 150

093-4

"sella turcica"

The pituitary fossa

Dr Davis advised: -

give to heart, let rest

go!

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7324
Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Annie Novella Hoopes</i> | | | 2. DATE OF DEATH <i>August 23, 1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Md.</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>#504 Maine Ave</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore City</i> | | |
| c. Length of stay in Baltimore <i>80 yrs</i> | | | D. STREET ADDRESS (If rural, give location) <i>#504 Maine Ave</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>August 27, 1868</i> | | 9. AGE (in years last birthday) <i>81</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Annapolis Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>George Baker Collins</i> | | | 14. MOTHER'S MAIDEN NAME <i>Dorothy Francis Lee</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | 17. INFORMANT <i>George W. Hoopes -</i> | | |
| | | | ADDRESS | | |

| | | |
|---|---|---|
| 18. <i>Heart</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH (A) <i>Myocarditis</i> DUE TO <i>Age</i> (B) <i>Detrusor Sphincter</i> DUE TO (C) | INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>2 years</i> |
|---|---|---|

| | | |
|---|---|--|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

| | | | |
|--------------------------------------|----------------------------------|-----------------------------------|-----------------------------------|
| 23A. SIGNATURE <i>R. C. Smith</i> | M. D. <i>4509 Liberty Ave</i> | 23B. ADDRESS <i>Battle Md.</i> | 23C. DATE SIGNED <i>Aug 24</i> |
|--------------------------------------|----------------------------------|-----------------------------------|-----------------------------------|

| | | | |
|--|-------------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>Aug 26-50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i> | 24D. LOCATION (City, town, or county) (State) <i>Battle Md.</i> |
|--|-------------------------------|---|--|

| | | | |
|--|---|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 24 1950</i> | REGISTRAR'S SIGNATURE <i>Sturtevant Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>Edsworth Demas</i> | ADDRESS <i>5118 Sursum Park Ave</i> |
|--|---|---|--|

09.3.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

211

(copy)

1871

1871

1871

1871

1871

1871

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1871

1871

1871

1871

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7325

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RENIE (RENA) BELLAMY

2. DATE
OF
DEATH

August 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

before admission

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

931 Mulberry

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1017 N. Arlington Avenue

C. Length of stay in Baltimore

20 yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 17, 1907

9. AGE (In years
last birthday)

43

If Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Decorator

10B. KIND OF BUSINESS OR
INDUSTRY

Flower

11. BIRTHPLACE (State or foreign country)

N. C.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Robert Nixon

14. MOTHER'S MAIDEN NAME

Carolyn Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Susie Chisom, 1017 N. Arlington Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) **Carcinoma of breast with wide-spread**

metastases

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Duncanson

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

August 24, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

B

24B. DATE

8-28-50

24C. NAME OF CEMETERY OR CREMATORY

XXXXXX XXXXXX XXXXXX

24D. LOCATION (City, town, or county)

(State)

CHADBURN, NO. CAROLINA

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Samuel W. Sullivan, Jr.

AUG 24 1950

5146R 050.0 1011 N. Arlington Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PRECISELY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEATH CERTIFICATE

FILE NO.

DATE

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF ARRIVAL

PLACE OF ARRIVAL

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7326

BIRTH NO. 50 7326

1. NAME OF DECEASED
(Type or Print)

John Williams

2. DATE
OF
DEATH

8-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN, (If outside corporate limits, write full name and give
township)

Baltimore

10-02

D. STREET ADDRESS (If rural, give location)

823 N. Spring St

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

negro

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

1876

9. AGE (in years
last birthday)

73

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Industry

11. BIRTHPLACE (State or foreign country)

Unk. Known

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Unk. Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

443X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, apoplexy, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral Vascular Accident

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B)

Hypertensive Vascular Disease

DUE TO

(C)

unknown

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-19-1950 to 8-21-1950, that I last saw the
deceased alive on 8-21-1950, and that death occurred at 6:40 A. M., from the causes and on the date stated above.

23A. SIGNATURE

J. G. Thompson

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-22-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/25/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Livingston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Little Gross 1408 Ashland

VS 150

97099

083.1

and

1-22-20

1-22-20

George Newman letter 8 days
to 1-22-20

1-22-20

1-22-20

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Ollie May Turner

2. DATE
OF
DEATH

August 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

430 N. Carey St.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

430 N. Carey St.

c. Length of stay in Baltimore

8 Yrs.

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 17, 1919 31

9. AGE (In years
last birthday)11 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Barn Well S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jessie Ashley

14. MOTHER'S MAIDEN NAME

Rosie Dunbar

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

George Turner 430 N. Carey St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

3 months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 26, 1950 to Aug 22, 1950, that I last saw the
deceased alive on Aug 22, 1950, and that death occurred at 11 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Ellenton S.C.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 24 1950

Chas. G. Cooper 512 N. Carrollton

Ave.

VS 150

Chas. G. Cooper 013.2

100

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7328

BIRTH NO. 50-17639

1. NAME OF DECEASED
(Type or Print)

Baby Boy Gerber

2. DATE
OF
DEATH

Aug. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
A. STATE B. COUNTY before admission)

Maryland

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore, 9-06

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

1608 E. 30th Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 23, 1950

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

45

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Louis L. Gerber

14. MOTHER'S MAIDEN NAME

Elizabeth Lutz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Actelectasis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 23, 1950 to Aug. 23, 1950, that I last saw the
deceased alive on Aug. 23, 1950, and that death occurred at 8:30 PM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 25 1950

VS 150

161.1

DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

SIGNATURE OF WITNESS

SIGNATURE OF DECEASED

SIGNATURE OF NEXT OF KIN

SIGNATURE OF BURIAL OFFICIAL

SIGNATURE OF INTERVIEWER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7329

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Glenn E Rice

2. DATE
OF
DEATH

8/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Maryland General Hospital

C. Length of stay in Baltimore

232 Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Parktonville 53-00

D. STREET ADDRESS (If rural, give location)

7209 Park Drive #14

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

3/13/93

9. AGE (In years last birthday)

57

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

machinist

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Coast Guard

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Rice

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Carrie Bitter Rice (wife) as above

ADDRESS

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema & rt. effusion

unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease

unknown

(C) Hypertensive cardiovascular disease

unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic + acute congestion of heart & lungs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/24, 1950, to 8/24, 1950, that I last saw the deceased alive on 8/24, 1950, and that death occurred at 10:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louise Candler M.O.

23B. ADDRESS

Maryland General Hosp

23C. DATE SIGNED

8/24

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland

24D. LOCATION (City, town, or county)

Taylor Ave

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Medred J. Blight 6009 Haynes

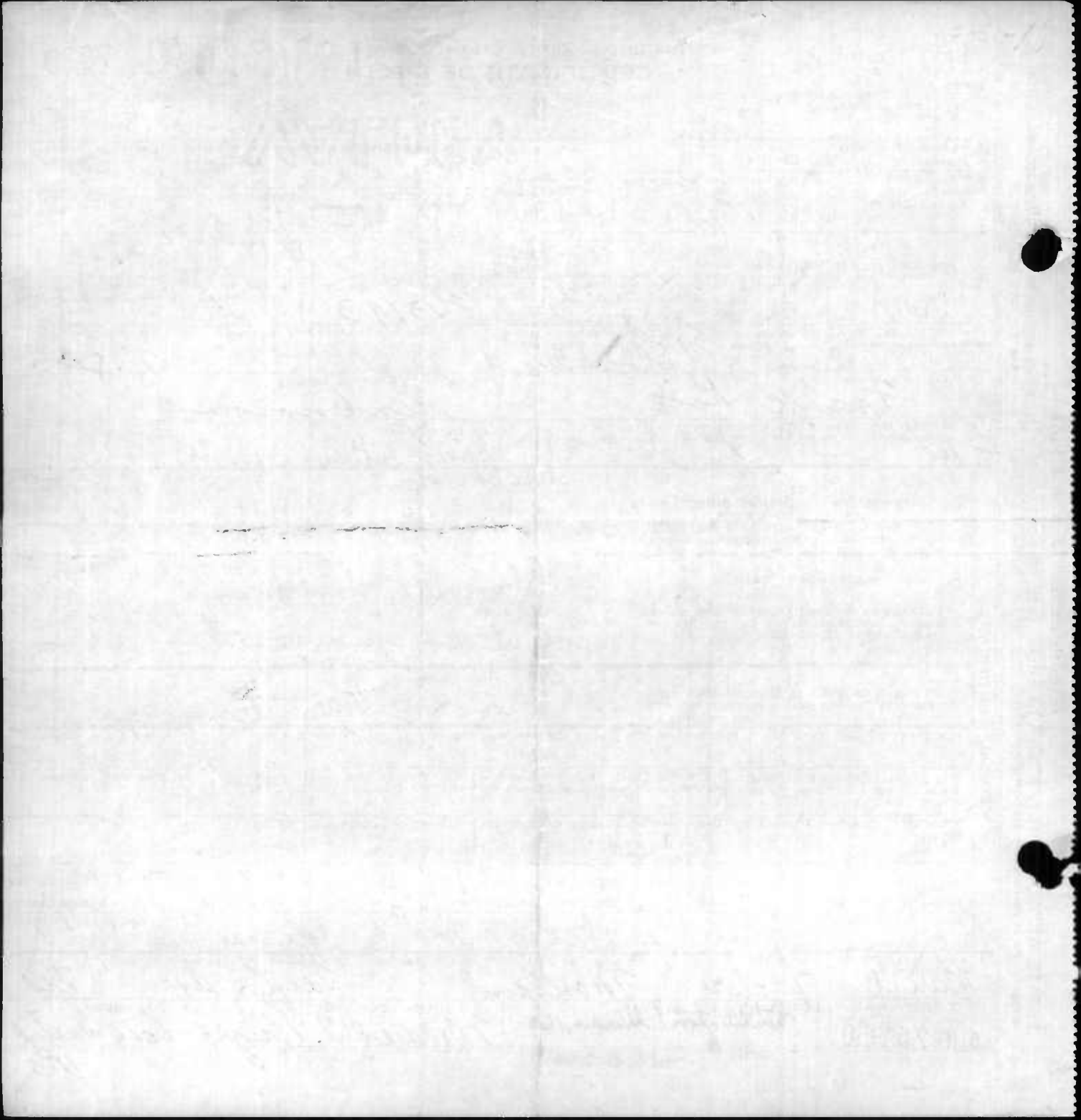
ADDRESS

AUG 25 1950

VS 150

54491

093.4



SARAH - MARGARET - RIXSE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 7330

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Margaret (Sarah) Rixse

2. DATE
OF
DEATH

24 Aug 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

English Consul (Chancery)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

3300 English Consul Ave.

D. STREET ADDRESS (If rural, give location)

3300 English Consul 25-42

c. Length of stay in Baltimore

30 yrs.

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb 24, 1892

9. AGE (In years
last birthday)

58

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Savannah, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Edward Linchcomb

14. MOTHER'S MAIDEN NAME

Minerva Ann Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

(Thelma Michel)
Daughter-in-law

ADDRESS

405 E. Ave.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Carcinoma, cervix

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

lower nephron sclerosis

DUE TO

Carcinoma, cervix, with metastasis 6 yrs.

3 days

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Biopsy

19B. MAJOR FINDINGS OF OPERATION

Cancer

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Aug 1950, to 24 Aug 1950, that I last saw the deceased alive on 22 Aug 1950, and that death occurred at 8:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Graph B. Gorey

23B. ADDRESS

1311 E. Belvedere

23C. DATE SIGNED

24 Aug 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Madonridge Memorial

24D. LOCATION (City, town, or county)

Loysey

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Md

25. FUNERAL DIRECTOR

604 E. 121st St Paul

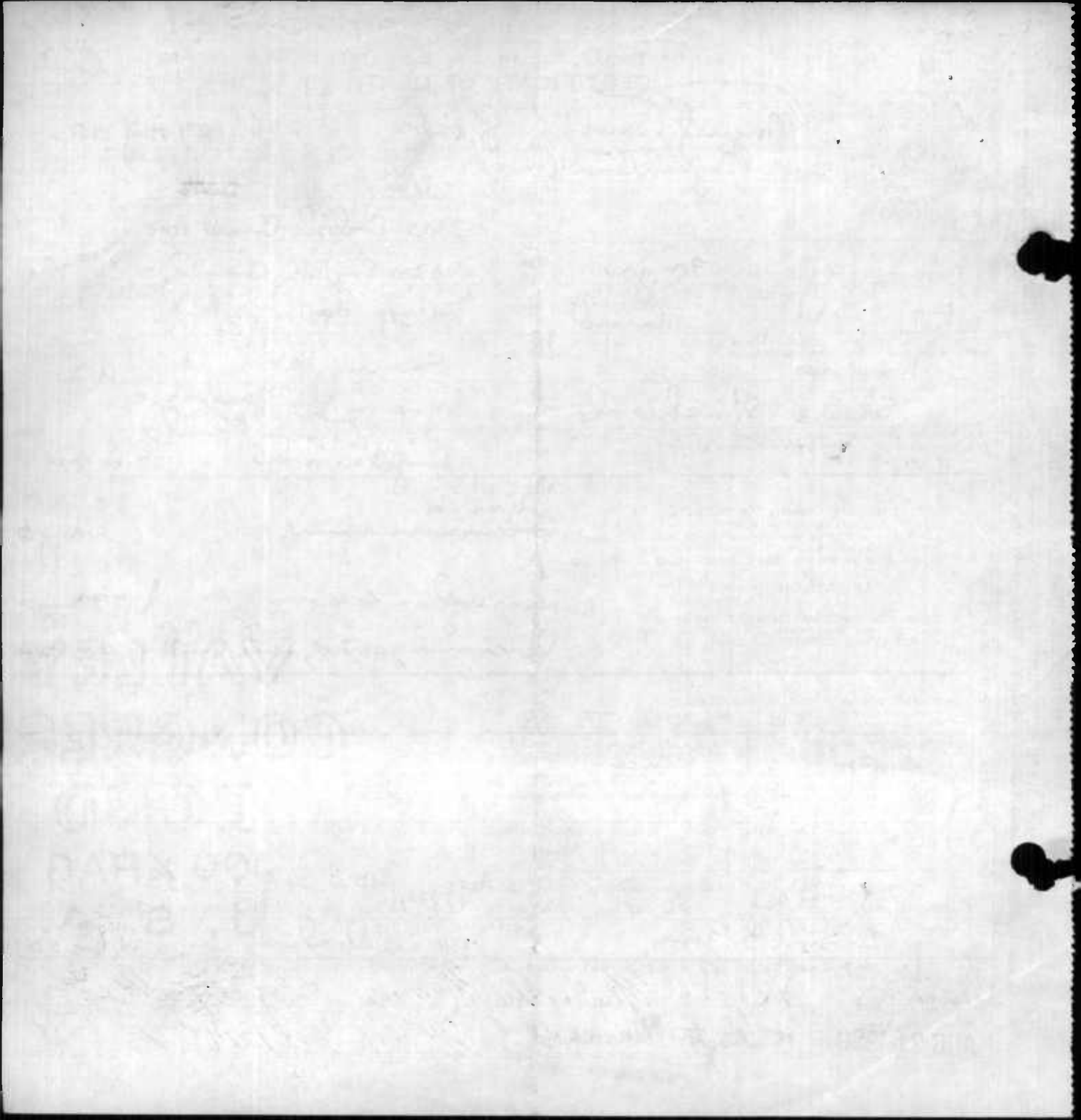
ADDRESS

121st St Paul

AUG 25 1950

VS 150

048.1



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Hyman Zeritsky*2. DATE
OF
DEATH*August 24, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE *md.* B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION*JOHN HOPKINS HOSPITAL*C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)
*Baltimore 15-09*D. STREET ADDRESS (If rural, give location)
*4009 Bateman Ave.*c. Length of stay in Baltimore *46 Yrs.*Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

11-26-18

9. AGE (in years)

67

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
*tailor*10B. KIND OF BUSINESS OR
INDUSTRY
shop

11. BIRTHPLACE (State or foreign country)

*Russia*12. CITIZEN OF
WHAT COUNTRY?
USA.

13. FATHER'S NAME

Sidney Zeritsky

14. MOTHER'S MAIDEN NAME

*Sarah Rae??*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
*no*16. SOCIAL
SECURITY NO.
216-18-0832

17. INFORMANT

ADDRESS

JOHN HOPKINS HOSPITAL

18.

199 H
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) *Carcinoma of primary site unknown*

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH*4 mos*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Carcinoma of mediastinum*

DUE TO

(C) *primary not known*

(over)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7-14, 1950* to *8-24, 1950* that I last saw the
deceased alive on *8-24, 1950* and that death occurred at *5458* m., from the causes and on the date stated above.

23A. SIGNATURE

Romane

M. D.

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

*11-24-26*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

8-25-50

24C. NAME OF CEMETERY OR CREMATORY

Maryland Lodge

24D. LOCATION (City, town, or county) (State)

*Baltimore, Maryland*DATE RECEIVED BY
LOCAL REGISTRAR*AUG 25 1950*

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Sal. Linnson, Bros

ADDRESS

10 North Ave.

VS 150

5906E

55E

giving for
possible anatomical
location

See Document File 50-7331

9-14-50

20

08-65006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HYATT, JACOB

2. DATE
OF
DEATH

August 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

15-L3

D. STREET ADDRESS (If rural, give location)

2548 Oswego Avenue

c. Length of stay in Baltimore 40 yrs.

Yrs.
Mos.
Days

5. SEX

m

6. COLOR OR RACE

w

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

m

8. DATE OF BIRTH

1887

9. AGE (In years
last birthday)

63

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR
INDUSTRY

Shop

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

David Hyatt

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lena Hyatt- 2548 Oswego Avenue

18.

H43X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebrovascular Accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cerebrovascular

DUE TO

(C)

Bleeding peptic ulcer

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

22. I hereby certify that I attended the deceased from Aug 22, 1950, to Aug 24, 1950, that I last saw the deceased alive on Aug 24, 1950, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Franker Winton

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-25-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Young Mens

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

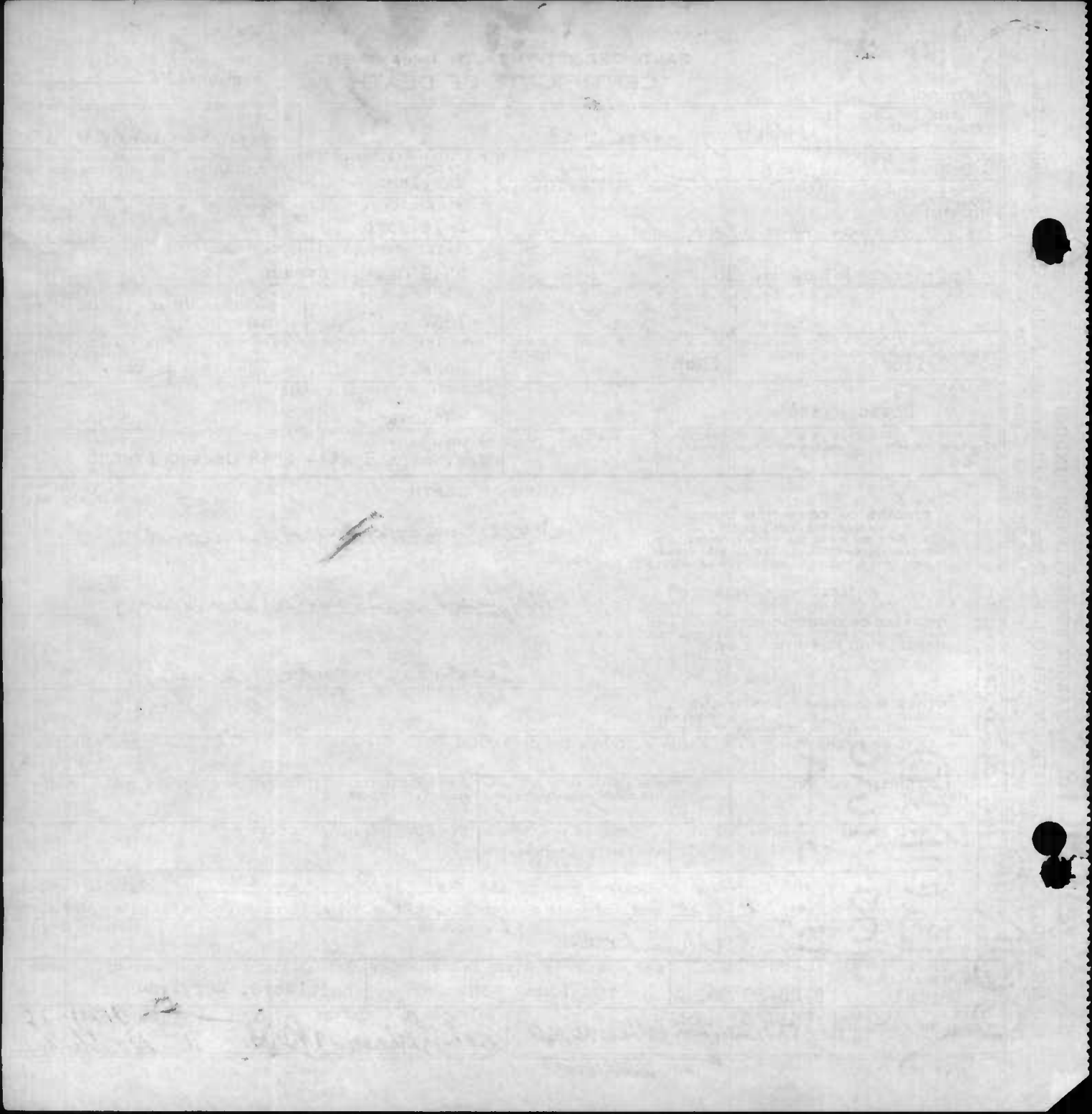
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Sal. Levinson & Bros

ADDRESS

1424-26 W. North Ave.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Nancy Grenville - Moran

2. DATE
OF
DEATH

Aug 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Mechburg 4

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. ~~STATE~~ Country

Australia

Australia

Australia

B. FULL NAME OF HOSPITAL OR INSTITUTION

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Melbourne

7-05

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

6-22-17

9. AGE (In years last birthday)

33

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

California

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Dr. D. S. Mercer

14. MOTHER'S MAIDEN NAME

Nancy Melodland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHN HOPKINS HOSPITAL

18.

201X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Tracheal + Bronchial Obstruction*

ONE TO

INTERVAL BETWEEN ONSET AND DEATH

3 mon.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hodgkins Disease*

ONE TO

6 yrs

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/26*, 19*50*, to *8/24*, 19*50*, that I last saw the deceased alive on *8/24*, 19*50*, and that death occurred at *11:00* a. m., from the causes and on the date stated above.

23A. SIGNATURE

Margaret Isaac Root MD

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

August 24, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

8/25/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Omaha, Neb.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 25 1950

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

Wm. J. Schner & Sons - Balt

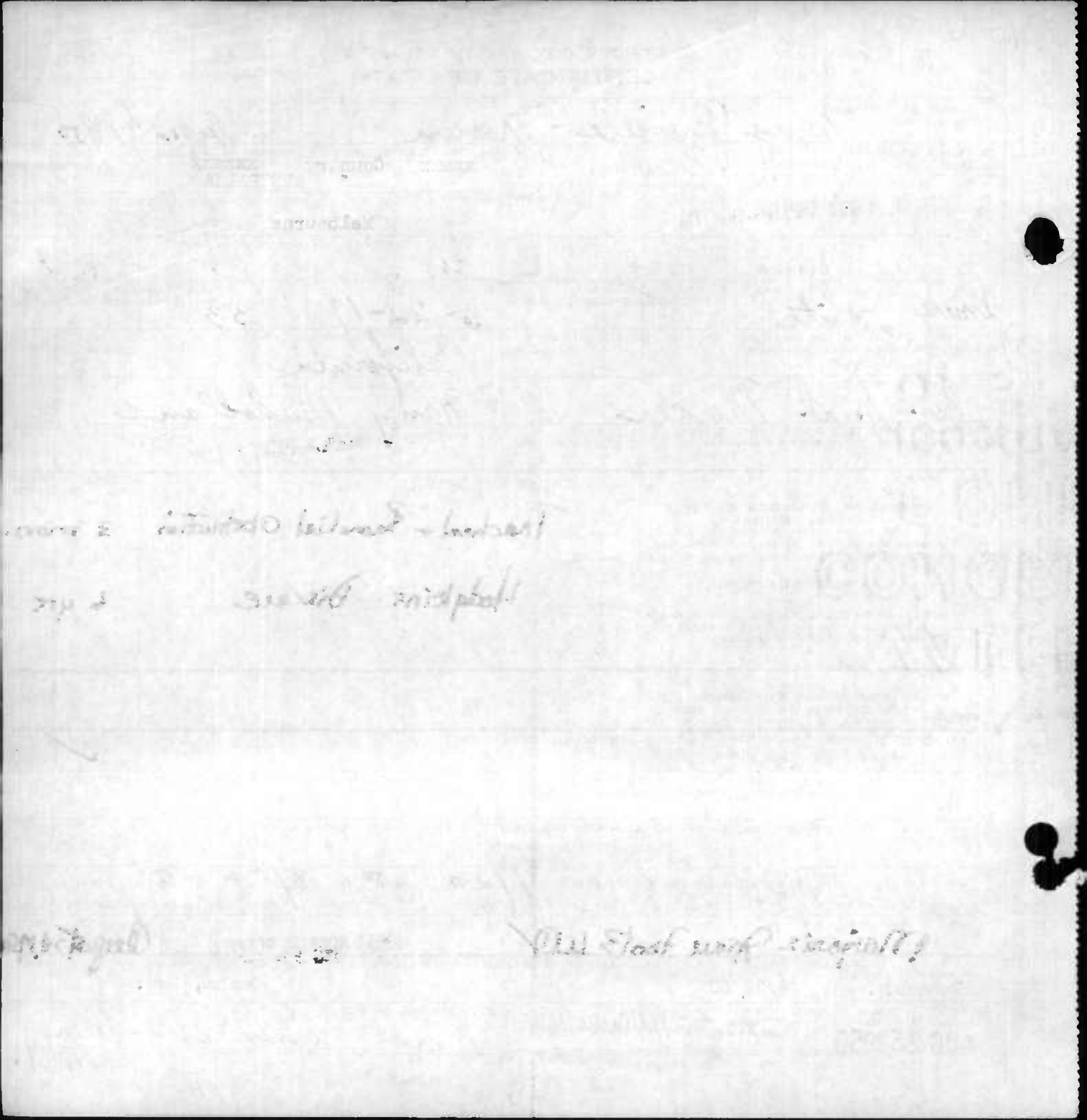
ADDRESS

VS 150

044.2

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.



50 7334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7334

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HARRY EDWARD DEMMITT

2. DATE

OF DEATH

August 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR US Marine Hospital

INSTITUTION

Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Catonsville

D. STREET ADDRESS (If rural, give location)

28 Edmondson Ridge Road

c. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

5/4/99

9. AGE (In years last birthday)

51

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesmanager

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore Sun

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edwin Demmitt

14. MOTHER'S MAIDEN NAME

Bertha Klein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18. 224 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Supracellar cyst area of necrosis, left frontal hemisphere, cerebral

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 mos. Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 23, 1950, to Aug. 24, 1950, that I last saw the deceased alive on Aug. 24, 1950, and that death occurred at 3:20A m., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

M. D.

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

8/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 25 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. L. Lickner & Sons - Balto Md

ADDRESS

VS 150

2906U

056.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RGB

CERTIFICATE OF DEATH

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7335BIRTH NO. 325

| | | | | | |
|--|---------------------------|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) <u>Alexander Stevens Katzenberg</u> | | | 2. DATE OF DEATH <u>Aug. 23, 1950</u> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>B</u> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 13-03</u> | | |
| C. Length of stay in Baltimore <u>66 mo</u> Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) <u>2304 Eutaw Place</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u> | 8. DATE OF BIRTH <u>Sept 11 1884</u> | 9. AGE (In years last birthday) <u>66</u> | II Under 1 Year Months: Days: II Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Myer C. Katzenberg</u> | | | 14. MOTHER'S MAIDEN NAME <u>Hannah Benney</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |

| | | | | |
|--|--|--|---|--|
| 18. <u>451X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO | | CAUSE OF DEATH (A) <u>Dissecting Aneurysm</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | (B) <u>Arteriosclerosis</u> DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | |
| 19A. DATE OF OPERATION <u>8</u> | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED M. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from <u>Aug. 23, 1950</u> to <u>Aug 23, 1950</u> , that I last saw the deceased alive on <u>Aug 23, 1950</u> , and that death occurred at <u>9:15 p.m.</u> , from the causes and on the date stated above. | | | | |
| 23A. SIGNATURE <u>Shed S. Nelson</u> | | M. D. <u>Baltimore 18, Maryland</u> | 23B. ADDRESS <u>Union Memorial Hospital</u> 23C. DATE SIGNED <u>Aug 23, 1950</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>Aug 27, 1950</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Beth Hebrew Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Belair Rd. City Md.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 29 1950</u> | | REGISTRAR'S SIGNATURE <u>Frederick Williams</u> | 25. FUNERAL DIRECTOR <u>David Sondheim</u> ADDRESS <u>Pow 1902 Eutaw Place</u> | |

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

IN SENATE,
January 10, 1907.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE,
MAY 1, 1906.

ALBANY: JAMES BRADY, STATE PRINTER, 1907.

RECEIVED JAN 11 1907

OFFICE OF THE ATTORNEY GENERAL

ALBANY, N. Y.

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

CARRIE SCHULZ

2. DATE
OF
DEATH

AUG. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3018 LONATERRACE.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **MARYLAND** B. COUNTY **BALTIMORE CITY**

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

BALTIMORE 27-02

D. STREET ADDRESS (If rural, give location)

3018 LONATERRACE.

c. Length of stay in Baltimore

57 Yrs
Yrs. Mos. Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

APRIL 4, 1868

9. AGE (In years last birthday)

82

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE.

10B. KIND OF BUSINESS OR INDUSTRY

HOME.

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JOHN W. SCHULTZ

14. MOTHER'S MAIDEN NAME

CHRISTINA FOGELER.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE.

17. INFORMANT **3018 LONATERRACE**

MARIE SUTER (SISTER)

18.

422.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **ARTERIOSCLEROTIC**
DUE TO **CARDIO-VASCULAR DISEASE**

INTERVAL BETWEEN ONSET AND DEATH

(?)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

NONE.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-30 - 1950** to **8-22 - 1950**, that I last saw the deceased alive on **8-19 - 1950**, and that death occurred at **2:20 p. m.**, from the causes and on the date stated above.

23A. SIGNATURE

Dr. Thos. Karlan

M. D.

23B. ADDRESS

4230 Loch Raven Blvd.

23C. DATE SIGNED

8-22-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 25/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Leander

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 25 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Philip Henry's Sons

ADDRESS

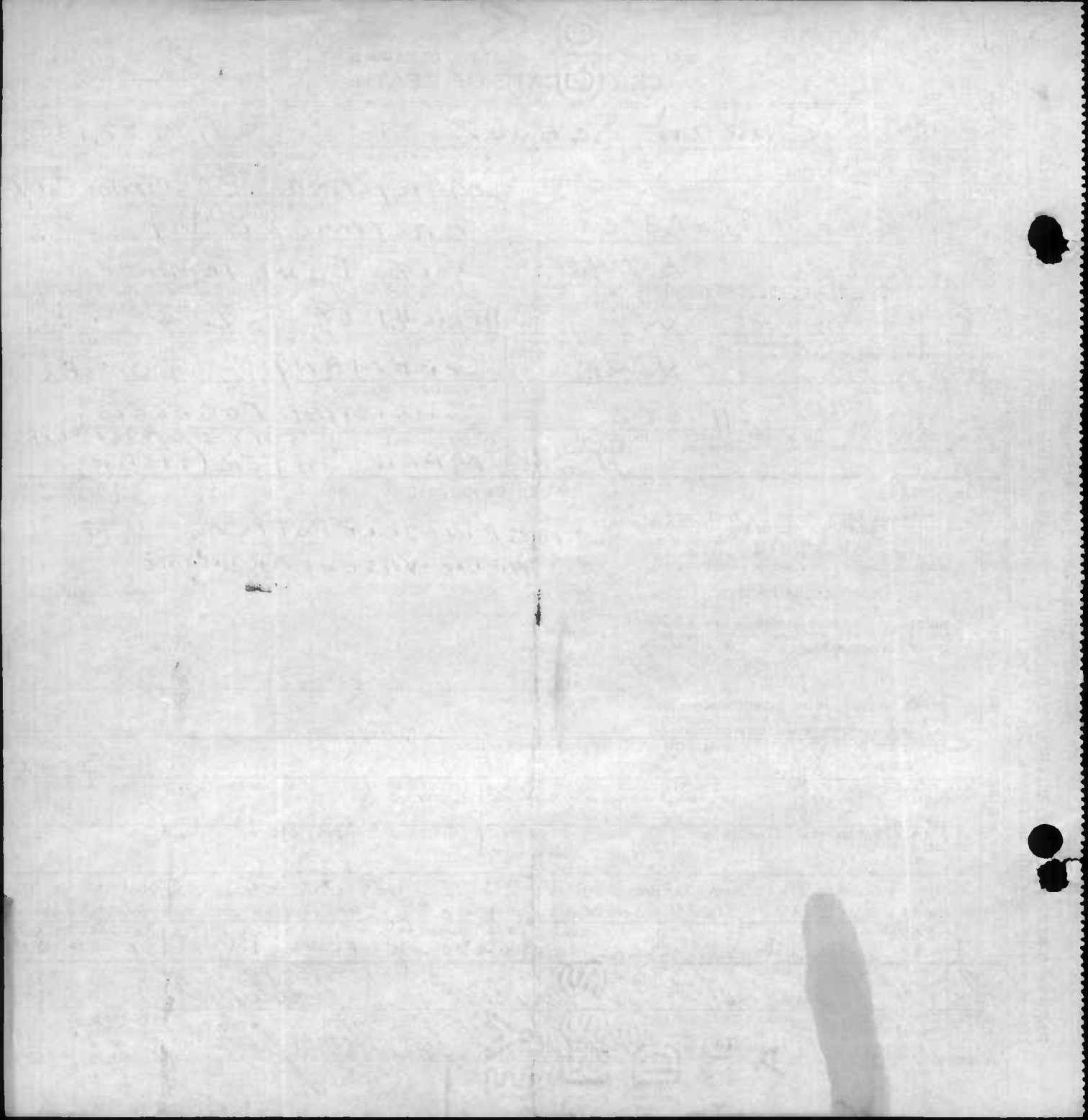
3024 Calverton St.

VS 150

093.40

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Sinclair

2. DATE
OF
DEATH

8/22/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

Foster

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION

1514 May Court

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto. City 6-85

D. STREET ADDRESS (If rural, give location)

1514 May Court

C. Length of stay in Baltimore

30 Yrs.

Yrs.
Mos.
Days

5. SEX

Male

Col.

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/30/1871

9. AGE (In years last birthday)

79

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Contractors

11. BIRTHPLACE (State or foreign country)

Crapepole Md

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Denard

Foster

14. MOTHER'S MAIDEN NAME

Emley

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Bertha Johnson 210 Asquith St

18.

581.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

massive Hemorrhage
Cirrhosis of the liver

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, to Aug. 21, 1950, that I last saw the deceased alive on July, 1950, and that death occurred at 7 30 m., from the causes and on the date stated above.

23A. SIGNATURE

Morris G. Fine

M. D.

23B. ADDRESS

115 Asquith St

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/25/50 int calvary cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 25 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Clayton O. Wilson 1050 Brantly

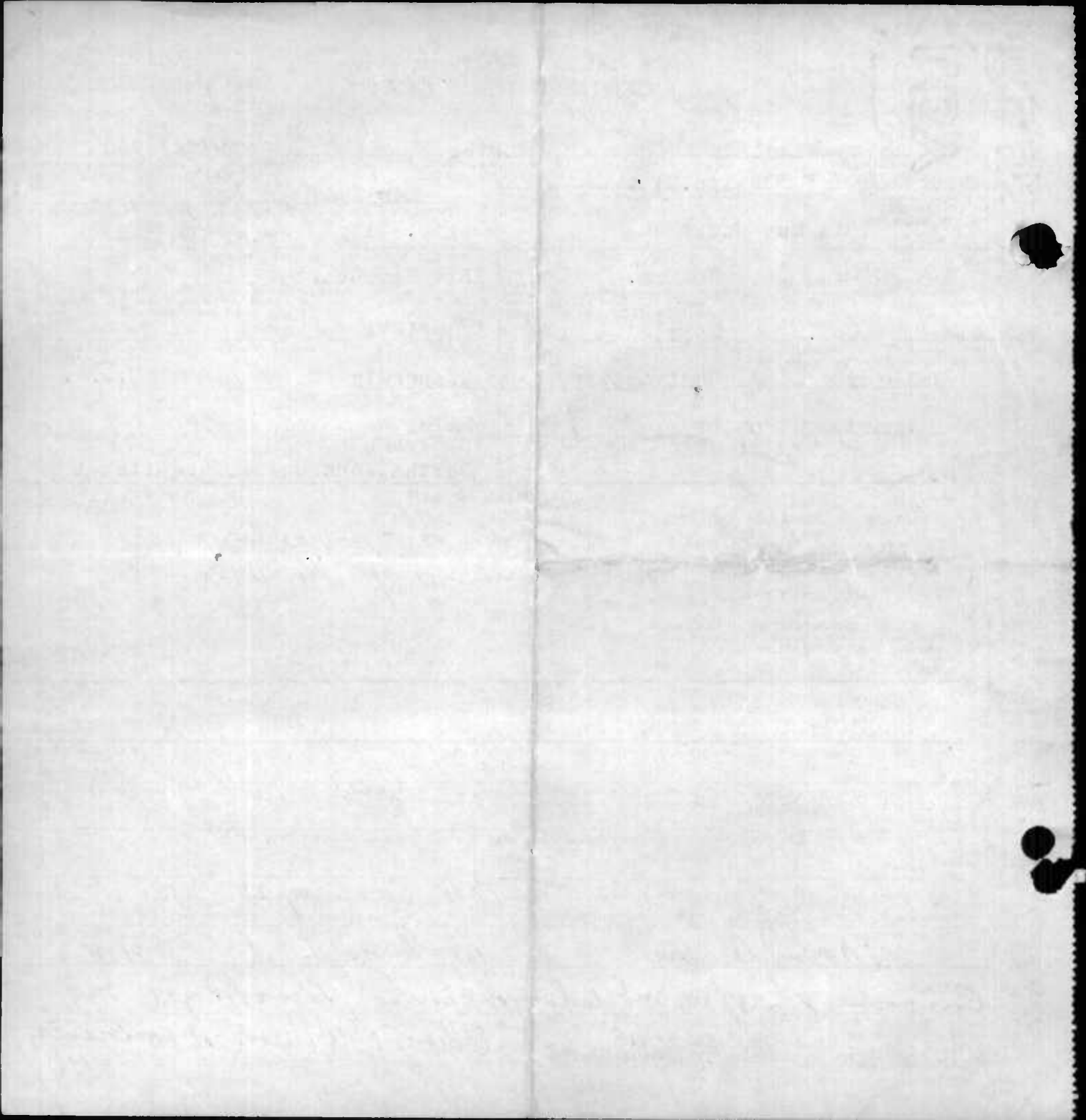
ADDRESS

VS 150

124.1

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. 49-049311. NAME OF DECEASED
(Type or Print)Milton Blackstone2. DATE
OF
DEATHAug 22, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

Burg Hal 3b. FULL NAME OF
HOSPITAL OR
INSTITUTIONJOHNS HOPKINS HOSPITAL4. USUAL RESIDENCE (Where deceased lived, if institution: residence
a. STATE Md b. COUNTY 5-01 before admission)c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimored. STREET ADDRESS (If rural, give location)
120 Aisquith St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Child

8. DATE OF BIRTH

4-8-19499. AGE (in years
last birthday)1 yrIf Under 1 Year
Months: Days4If Under 24 Hours
Hours: Min.410a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Harry Blackstone

14. MOTHER'S MAIDEN NAME

Marothy Jackson15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL18. E916.0,

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Severe Body BurnsINTERVAL BETWEEN
ONSET AND DEATH36 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

CERTIFICATION APPROVED BY

Robert B. McFadden, M.D.RBFisher M.D.

CHIEF OR ASST. MEDICAL EXAMINER

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)Home21c. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)120 Aisquith St

21d. TIME (Month) (Day) (Year) (Hour)

August 20, 1950 9 P

21e. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

When stove overturned22. I hereby certify that I attended the deceased from 8-20-, 1950 to 8-22-, 1950 that I last saw the
deceased alive on 8-22-, 1950 and that death occurred at 6:15 m., from the causes and on the date stated above.

23a. SIGNATURE

William F. Rindoff

M. D.

23b. ADDRESS

JOHNS HOPKINS HOSPITAL

23c. DATE SIGNED

8-22-5024a. BURIAL, CREMA-
TION, REMOVAL (Specify)Burial

24b. DATE

8/26/50

24c. NAME OF CEMETERY OR CREMATORY

Int Calvary cem

24d. LOCATION (City, town, or county)

Brooklyn md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Elmer Wilson

ADDRESS

1000 Brantly st

VS 150

N-949-2To be approv. by Med Exam181.0

George Ford from 10/10/10

None

None

None

Amst 10/10/10

100 Air with 10
X Clothes - right on fire

William - 10/10/10

10-10-10

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7339

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL SUMMERVILLE (Charles)

2. DATE
OF
DEATH

Aug 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland OSLER 2

B. FULL NAME OF (If not in hospital or institution, give street address or location)

JOHN HOPKINS HOSPITAL

Yrs.
Mos.
Days

c. Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4-11-90

9. AGE (in years
last birthday)

60

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

apt. house

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry

14. MOTHER'S MAIDEN NAME

Ruth Bear

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT JOHN HOPKINS HOSPITAL ADDRESS

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Intra-cerebral hemorrhage 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Vascular Disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-22-50

19B. MAJOR FINDINGS OF OPERATION

hemorrhage into left cerebrum

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-21, 1950, to 8-23, 1950, that I last saw the
deceased alive on 8-23, 1950, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

H. G. Lindford

M. D.

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

8-24-50

24A. BURIAL, CREMA-
TION, REMOVA (Specify)Burial
DATE RECEIVED BY
LOCAL REGISTRAR

24B. DATE

8/26/50

24C. NAME OF CEMETERY OR CREMATORY

St Peter's cem.

24D. LOCATION (City, town, or county)

St Marys co md

(State)

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Elroy O. Wilson 1000 Beauty ave

ADDRESS

AUG 25 1950

VS 150

77074

083.1

UNITED STATES DEPARTMENT OF AGRICULTURE

(Circular)

May 1910

Washington

1910

1910

1910

1910

1910

1910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7340

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lawrence E. Lyons

2. DATE
OF
DEATH

August 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

12-02

D. STREET ADDRESS (If rural, give location)

2934 Greenmount Ave.

C. Length of stay in Baltimore

7 Years

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 11, 1872

9. AGE (In years
last birthday)

78

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Stone Mason

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Daniel Lyons

14. MOTHER'S MAIDEN NAME

Johanna Dacey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Cerebro Vascular Accident

7 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A)

DUE TO

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Broncho-pneumonia

7 days

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-26-1943 to 8-23-1950, that I last saw the
deceased alive on 8-23-1950 and that death occurred at 8:45 PM, from the causes and on the date stated above.

23A. SIGNATURE

J. H. Hogan

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

8-24-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-26-1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Family

24D. LOCATION (City, town, or county)

Harrisonville, Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

F.C. Higinbotham, Ellicott City, Md.

AUG 25 1950

VS 150

083.1

CONFIDENTIAL
ATTN

PLEASE WRITE CORRECTLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P-536
50 7341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7341

| | | | | | |
|---|---------------------------|---|-----------------------------------|---|----------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Mack (Max) Pendergrast | | 2. DATE OF DEATH 8-23-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. City</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore <i>9-09</i> | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals | | D. STREET ADDRESS (If rural, give location) 1302 N. Central Avenue | | c. Length of stay in Baltimore 20 Yrs. | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH July 24, 1904 | 9. AGE (in years last birthday) 46 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seaman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Chemical Worker</i> | | 11. BIRTHPLACE (State or foreign country) <i>South Carolina</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME Alex Pendergrast | | 14. MOTHER'S MAIDEN NAME Missouri Reed | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Records* Balto. City Hospitals Eastern Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>146 X 1</i> Carcinomatosis | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Squamous- cell Carcinoma of Nasopharynx | | INTERVAL BETWEEN ONSET AND DEATH 5 Mos. | |

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>7-30</i> 19 <i>50</i> , to <i>8-23</i> 19 <i>50</i> , that I last saw the deceased alive on <i>8-23</i> 19 <i>50</i> , and that death occurred at <i>4:42</i> p. m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | 23B. ADDRESS 4940 Eastern Avenue | | 23C. DATE SIGNED 8-24-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | | 24B. DATE <i>8/27/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Brooklyn</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Brooklyn</i> | | 24E. NAME OF CEMETERY OR CREMATORY <i>Brooklyn</i> | | 24F. LOCATION (City, town, or county) (State) <i>Brooklyn</i> | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1950 | | REGISTRAR'S SIGNATURE <i>Huntington Williams</i> | | FUNERAL DIRECTOR <i>Elroy A. Wilson</i> | |
| VS 150 | | | | | |

9704R 045.6

13. 10. 1917

Received from Mr. J. H. Smith

for 1/2 of 100 shares of
the company at 100/- each

67-652

50 7342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7342

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT TARRING

2. DATE
OF
DEATH

8-24-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland
Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

ST. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53000

c. Length of stay in Baltimore

3 yrs.

D. STREET ADDRESS (If rural, give location)

821 S. Warwick Road

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH (If rural, give location)

8-24-1904

9. AGE (In years last birthday)

79

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

composer

10B. KIND OF BUSINESS OR INDUSTRY

J. J. American Paper

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

WILLIAM Tarring

14. MOTHER'S MAIDEN NAME

Anna G. Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

131-10-1432

17. INFORMANT

Joseph Incisardi, 821 Warwick Rd.

ADDRESS

1B.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Hypertensive C. V. D.

DUE TO

(B) Atherosclerosis

DUE TO

(C) Prostatic CA.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/4, 1950, to 8/24, 1950 that I last saw the deceased alive on 8/24, 1950 and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John C. Healy, M. D.

23B. ADDRESS

St. Agnes

23C. DATE SIGNED

8/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 26/50

24C. NAME OF CEMETERY OR CREMATORY

Landon Park

24D. LOCATION (City, town, or county)

Barto. and

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Antington Williams, M.D.

25. FUNERAL DIRECTOR

Harry H. Ditzler, 4101 Edmondson Ave

ADDRESS

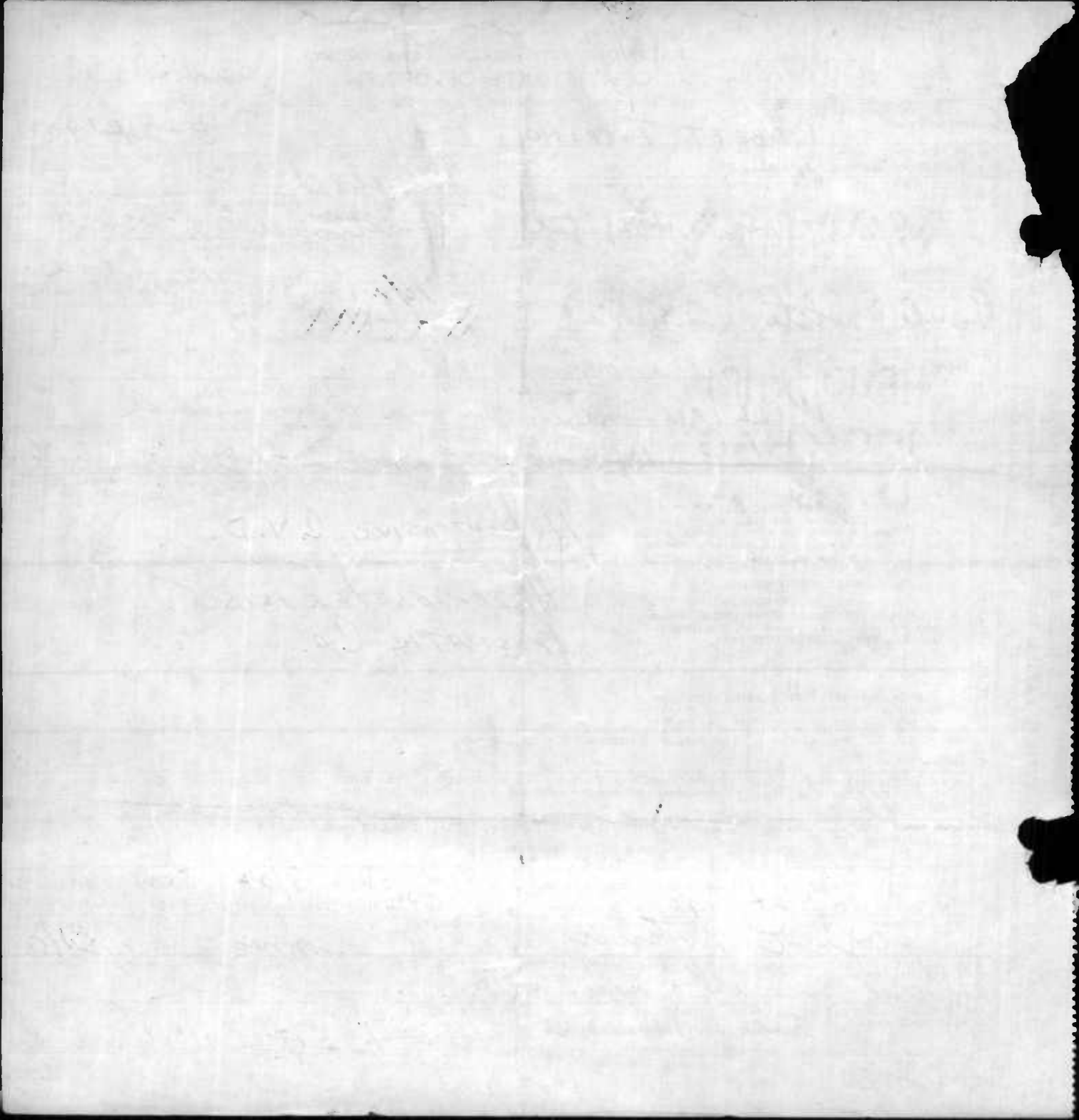
VS 150

AUG 25 1950

69060

051.2

Ave



LC
14090050

7342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7343

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Byrd

2. DATE
OF
DEATH

Aug. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONBaltimore City Hospitals
4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

18-02

D. STREET ADDRESS (If rural, give location)

1127 W. Mulberry Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 18 1868

9. AGE (in years
last birthday)

82

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Mill Worker

10B. KIND OF BUSINESS OR
INDUSTRY

Lumber Mill

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Records* 4940 Eastern Avenue
Baltimore City Hospitals

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Vascular Accident

1 week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertension Cardio Vascular Disease 3 1/2 Days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Pneumonia

several
days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 22, 1950 to Aug. 22, 1950 that I last saw the
deceased alive on Aug. 22, 1950, and that death occurred at 2:15 PM, from the causes and on the date stated above.

23A. SIGNATURE

B. Byrd

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)Burial
DATE RECEIVED BY
LOCAL REGISTRAR

AUG 25 1950

24B. DATE

8-26-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cem.

24D. LOCATION (City, town, or county)

Lansdowne

(State)

Md.

REGISTRAR'S SIGNATURE

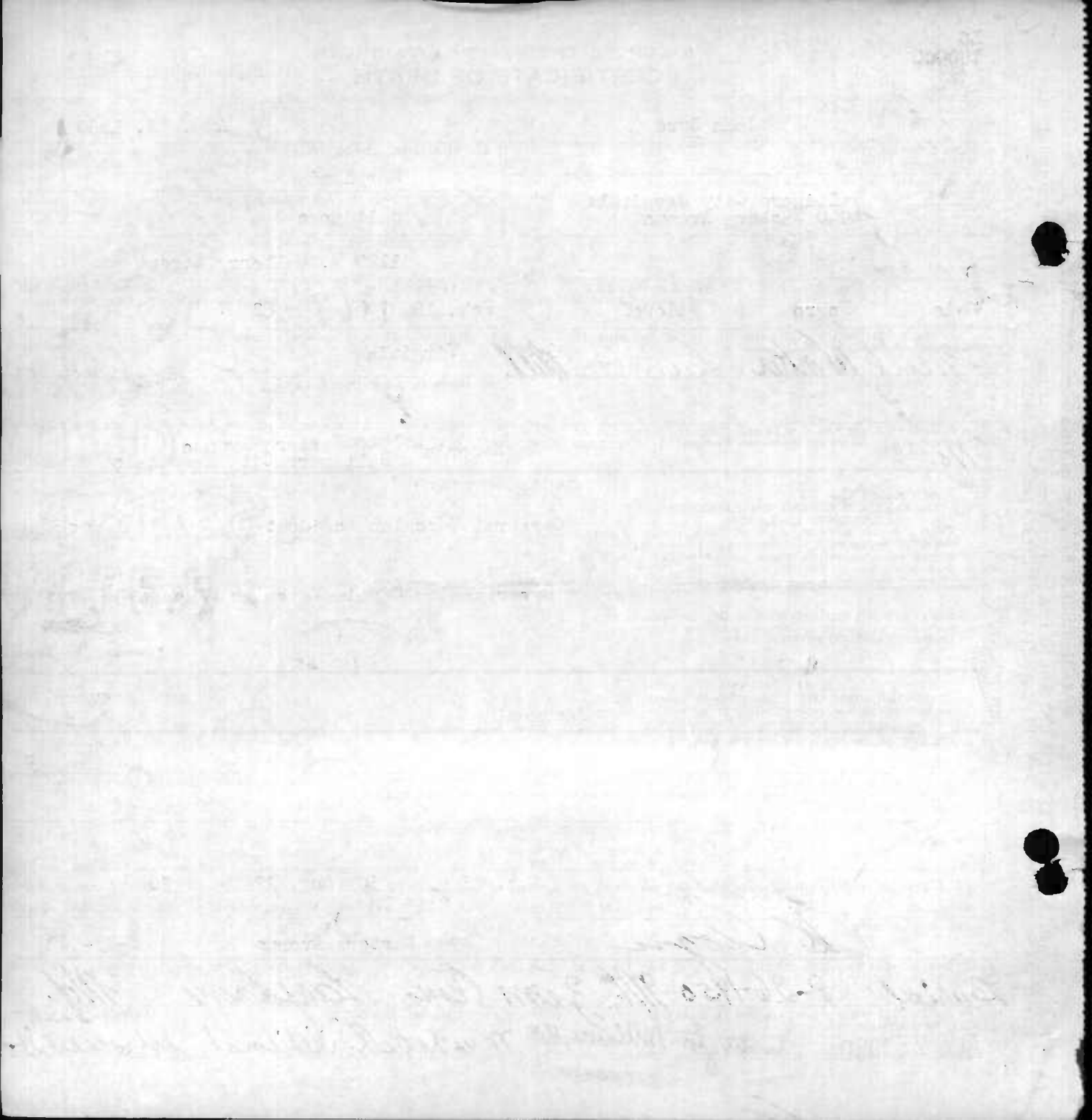
Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams

ADDRESS

Schroeder St.



| | | | | | |
|---|-------------------------------|--|--|--|---|
| 50 7344 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 50 7344 Registered No. | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) SARIE SHATOW | | | 2. DATE OF DEATH 8-24-50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 15-11 | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Sinai | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore 45 Yrs. 45 Mos. 45 Days | | | D. STREET ADDRESS (If rural, give location) 3714 W. Gold Spring Lane | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH | 9. AGE (In years, last birthday) 58 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Russia |
| 13. FATHER'S NAME Not Known | | | 14. MOTHER'S MAIDEN NAME Not Known ✓ | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Nathan Shatow ADDRESS Same | |
| 18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Massive collapse of left lung DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Organizing Bronchopneumonia of Right lung DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | | 19B. MAJOR FINDINGS OF OPERATION | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 26, 1950 , to Aug 24, 1950 , that I last saw the deceased alive on Aug 24, 1950 , and that death occurred at 12:15 p. m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Elmer Bergant M. D. | | 23B. ADDRESS Sinai Hospital | | 23C. DATE SIGNED 8/24/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-27-50 | | 24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men | |
| 24D. LOCATION (City, town, or county) Balto Md | | 24E. DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1950 | | 24F. REGISTRAR'S SIGNATURE Huntington Williams | |
| 24G. FUNERAL DIRECTOR Jack Lewis Inc | | 24H. ADDRESS 2100 Eutaw Pl | | 24I. DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1950 | |

STATE OF NEW YORK
COUNTY OF ALBANY

WILLIAM V. ...



Baltimore Health Dept
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

50 7345

50 7345

| | | | |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH- COUNTY <i>BALTIMORE CITY</i> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>MARYLAND</i> COUNTY <i>HARFORD</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>BALTIMORE</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>FOREST HILL RURAL</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3939 KESWICK ROAD</i> | | STREET ADDRESS (If rural, give location) <i>62-00</i> | |
| 3. NAME OF DECEASED (Type or Print) <i>HANNAH BALDWIN STREETT</i> | | 4. DATE OF DEATH <i>Aug 23, 1950</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i> | 8. DATE OF BIRTH <i>Nov. 4, 1869</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday <i>82</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <i>HARFORD CO., MD.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>SILAS BALDWIN</i> | | 14. MOTHER'S MAIDEN NAME <i>SUSAN ASHTON</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS | | | |

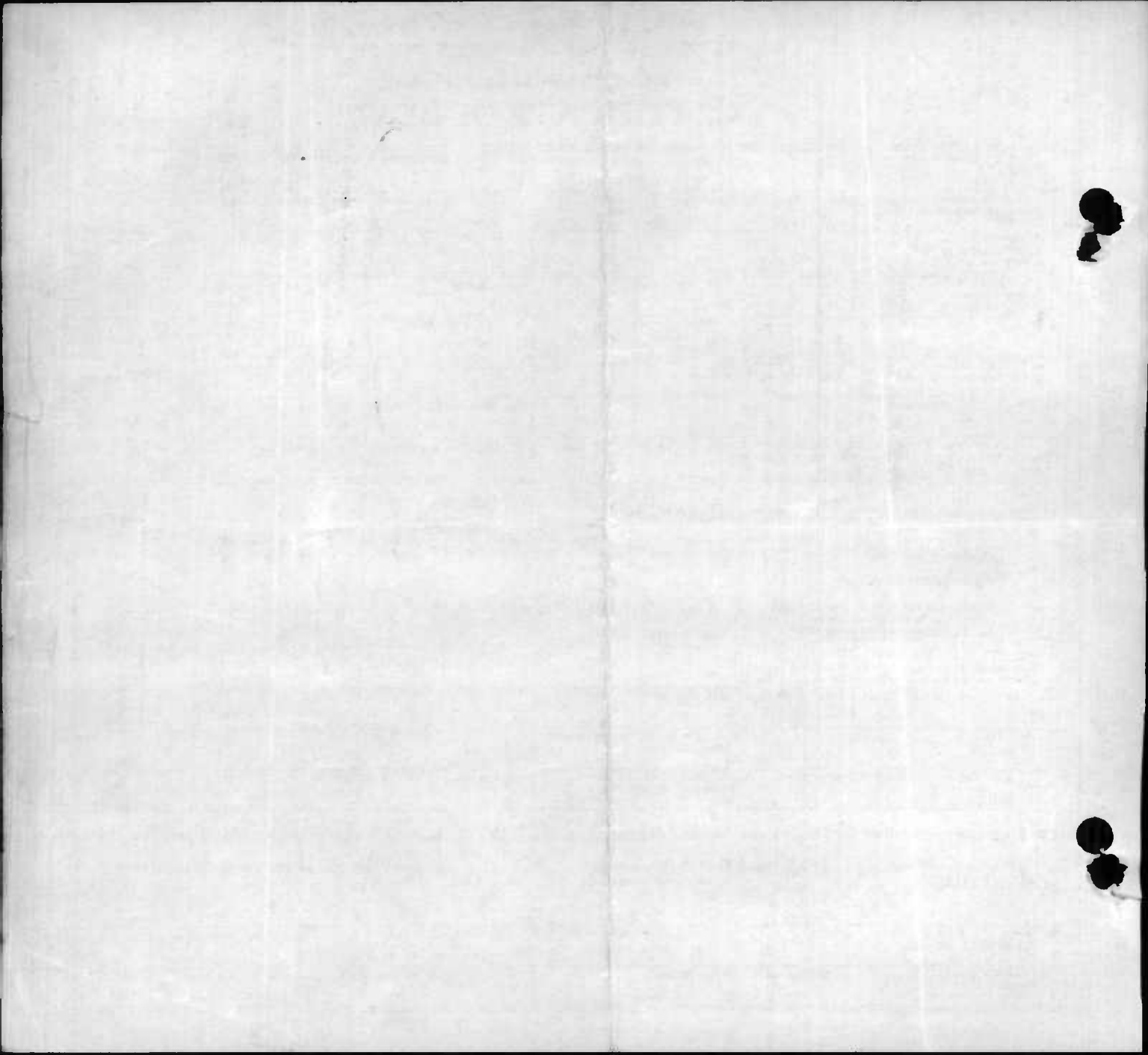
| | | | |
|---|---|---|----------------------------------|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 13. MEDICAL CERTIFICATION | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <i>Cardiovascular disease</i> | | | |
| Antecedent cause(s) (b) <i>Pneumonia</i> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from *April 15th*, 1950, to *August 23, 1950*, that I last saw the deceased alive on *August 20th*, 1950, and that death occurred at *5⁰⁰* P.M., from the causes and on the date stated above.

SIGNATURE *W. McKeown M.D.* ADDRESS *3005 St Paul St Baltimore, Md.* DATE SIGNED *August 23rd 1950*

| | | | |
|--|---|--|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i> | DATE | NAME OF CEMETERY OR CREMATORY <i>Rock Spring Emety</i> | LOCATION (City, town, or county) <i>Forest Hill, Md.</i> |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <i>Aug 25 1950</i> | 24/FUNERAL DIRECTOR <i>Jos. J. Foster, Bel Air, Md.</i> | ADDRESS | |

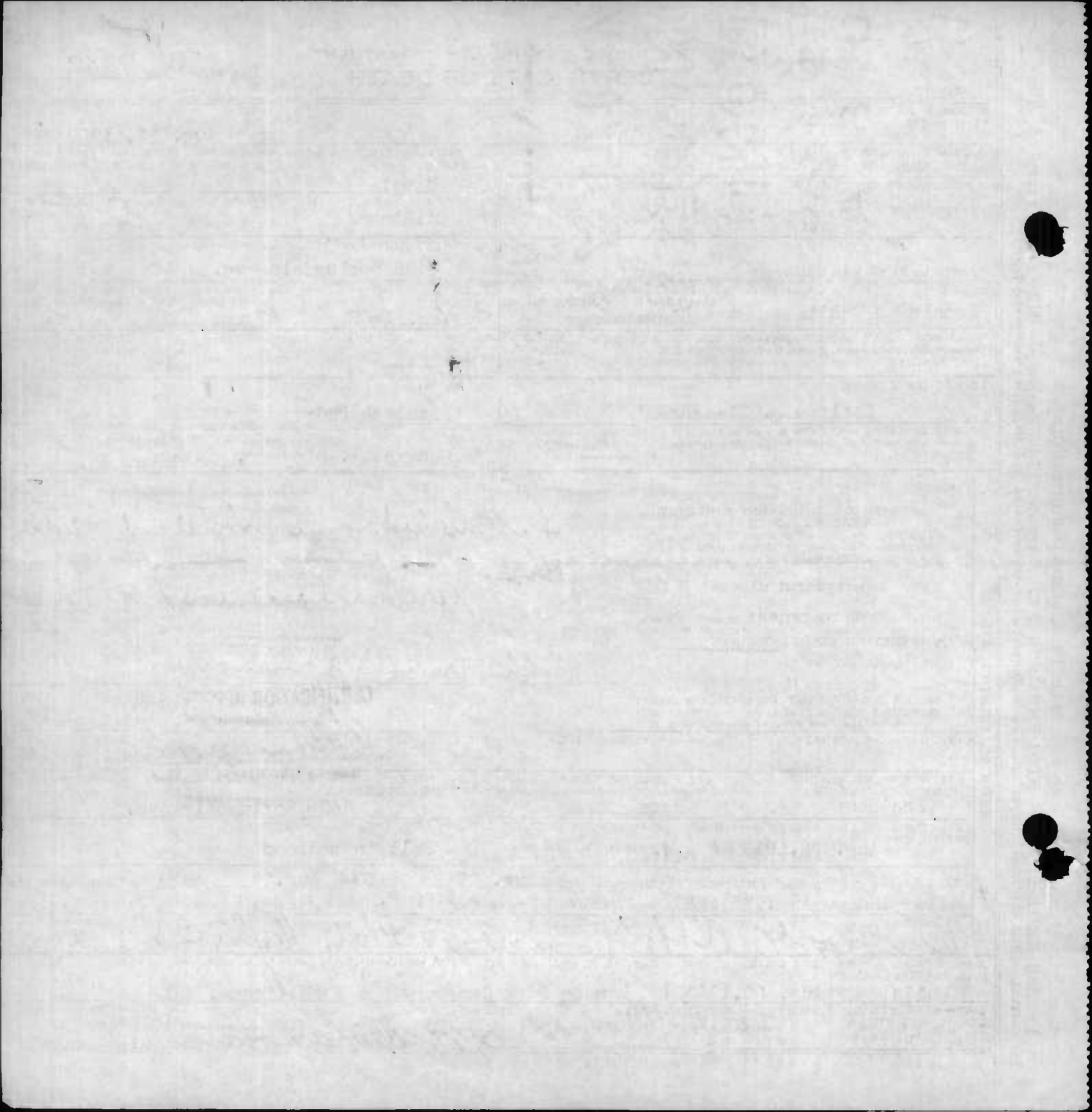
093.4



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7346

| | | | |
|--|-------------------------------|--|-------------------------------|
| BIRTH NO. 532 50 7346 | | 2. DATE OF DEATH <u>Aug. 23, 1950</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Clara R. Windsor</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-02</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>4408 Springdale Ave.</u> | | D. STREET ADDRESS (If rural, give location) <u>4408 Springdale Ave.</u> | |
| c. Length of stay in Baltimore <u>10</u> Yrs. <u>10</u> Days | | 8. DATE OF BIRTH <u>Oct. 8, 1862</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 9. AGE (In years last birthday) <u>87 yrs</u> | 10. Under 1 Year Months: Days |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u> | |
| 13. FATHER'S NAME <u>William B. Windsor</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Dudrow</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | 17. INFORMANT <u>Mr. Horace V. Windsor, 7007 Windsor Mill Rd Woodlawn, Md.</u> | |
| 16. SOCIAL SECURITY NO. <u>XXXX</u> | | 18. CAUSE OF DEATH 18. <u>331X I E903.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <u>Fell in bedroom - fractured Hip.</u> ANTECEDENT CAUSES (B) <u>Cerebral Vase Accident 2 days</u> (C) <u>Generalized Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION <u>6</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Accident</u> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u> | |
| 21C. WHERE DID INJURY OCCUR? <u>4408 Springdale Ave.</u> | | 20. AUTOPSY? <u>NO</u> | |
| 21D. TIME (Month) (Day) (Year) (Hour) <u>Aug. 22, 1950 2 A.M.</u> | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? <u>Fell in bedroom</u> | | 22. I hereby certify that I attended the deceased from <u>Aug. 22</u> , 1950 to <u>Aug. 23</u> , 1950, that I last saw the deceased alive on <u>Aug. 23, 1950</u> , and that death occurred at <u>1.40 P.m.</u> , from the causes and on the date stated above. | |
| 23A. SIGNATURE <u>Dr. Harry J. Abbott</u> | | 23B. ADDRESS <u>4509 Liberty Heights Ave.</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Aug. 26, 1950</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25. FUNERAL DIRECTOR <u>E. William Lamoreau</u> | | ADDRESS <u>4510 Liberty Heights Ave.</u> | |



PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 7347**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edgar Poe Sandrock

2. DATE
OF
DEATH

8/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Bethel Steel Co 1101 Key Highway

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3615 Ednor Rd

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

physician

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Dr. Wm. Christian Sandrock

14. MOTHER'S MAIDEN NAME

Laura Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes, World War 1

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dorothea P. Sandrock- 3615 Ednor Road

18. *4221*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Pericardial Hemorrhage*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Arteriosclerotic C. V. disease*
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) (Minute)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. P. Lubinski

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED *8/24/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9 - 26 - 50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

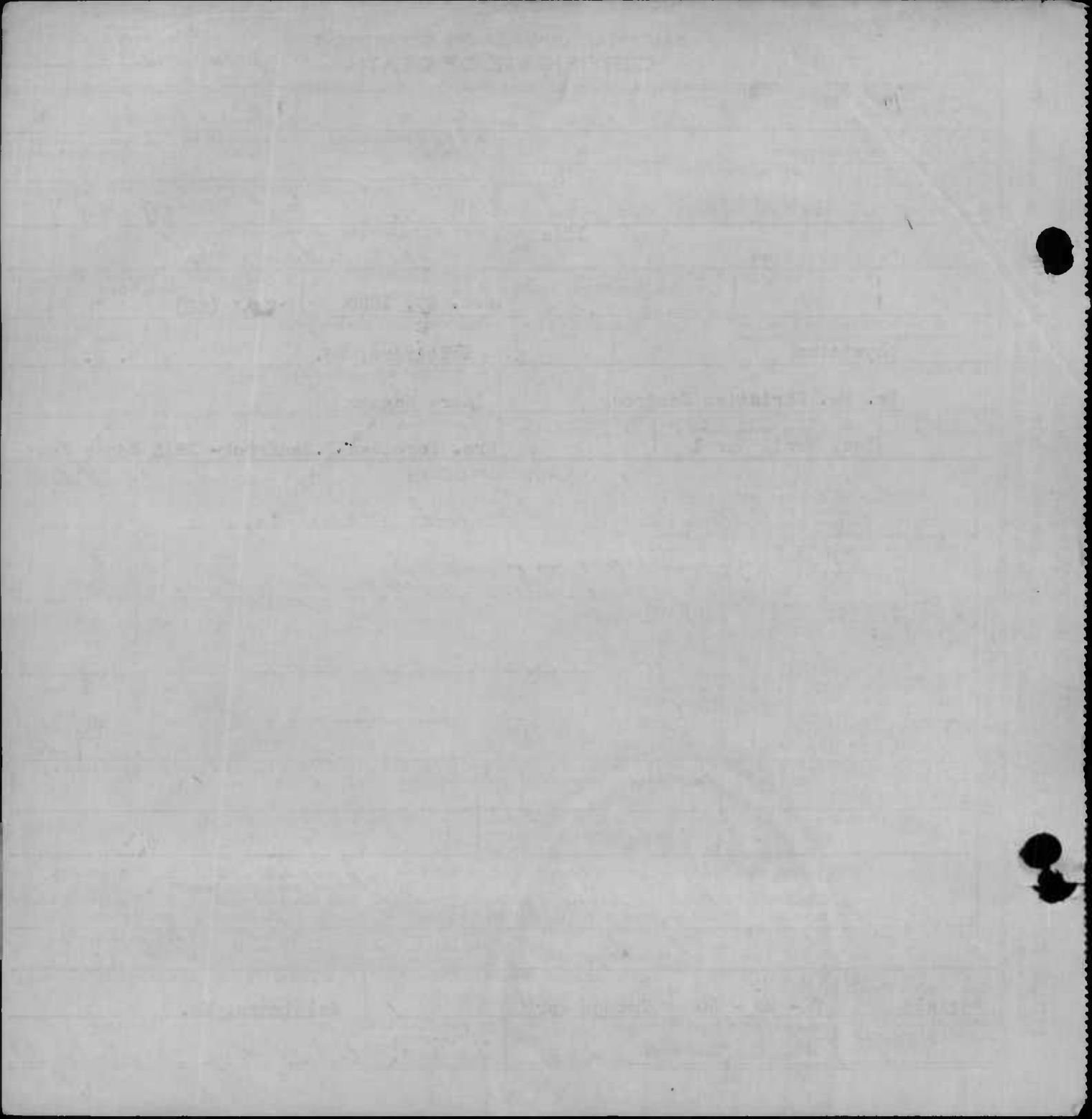
REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

John O. Mitchell & Sons 1900 Eutanol

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7348

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES SHAW

2. DATE
OF
DEATH

8-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution location)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
MARYLANDB. COUNTY
HOWARD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

CLARKSVILLE

6300

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

20

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE ☒ MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3-2-1889

9. AGE (in years
last birthday)

67

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BUILDER

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

Brookville Ind

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHAS. SHAW

14. MOTHER'S MAIDEN NAME

Margaret Hull

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Helen J. Shaw Clarksville Ind

ADDRESS

18. 450.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Post-operative Typhoid

INTERVAL BETWEEN
ONSET AND DEATH

3 dys

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

LIVER DAMAGE?

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-22-50

19B. MAJOR FINDINGS OF OPERATION

NONE.

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-5 1950 to 8-25 1950, that I last saw the deceased alive on 8-25 1950, and that death occurred at 5:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

F. J. Borgio

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8-25-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-27-50

24C. NAME OF CEMETERY OR CREMATORY

Linthicum Chapel

24D. LOCATION (City, town, or county)

Clarksville Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

F. C. Hightshorn

ADDRESS

Cause for which
operation was
performed

Autopsy diagnosis: *ganglioneuroma arteriosclerotic*

Es

10-13-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7349
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

359-W. Preston St.

C. Length of stay in Baltimore

5. SEX

F.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,

Widowed, Divorced (Specify)

Widowed

10. USUAL OCCUPATION (Give kind of work done during most profitable years)

Housewife

10A. KIND OF BUSINESS OR INDUSTRY

Own Home

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Md.

2. DATE OF DEATH

8/24/50

B. COUNTY

City

(before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

359-W. Preston St.

8. DATE OF BIRTH

? ? 1876

9. AGE (In years last birthday)

74

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Bina Jenkins

17. INFORMANT

Rosa Wright

359-W. Preston St.

18.

443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Congestive Heart Failure

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vas. Dis

DUE TO

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Jan 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 2, 1950, to Aug 23, 1950, that I last saw the deceased alive on Aug 23, 1950, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

George McDonald

23B. ADDRESS

844 Y Carey, Balt. Md.

23C. DATE SIGNED

8/25/50

24A. BURIAL CREMATION REMOVAL (Specify)

Buried

24B. DATE

8/26/50

NAME OF CEMETERY OR CREMATORY

Sumter S. Carolina

24C. LOCATION (City, town, or county)

South Carolina

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 25 1950

REGISTRAR'S SIGNATURE

Christington Williams

25. FUNERAL DIRECTOR

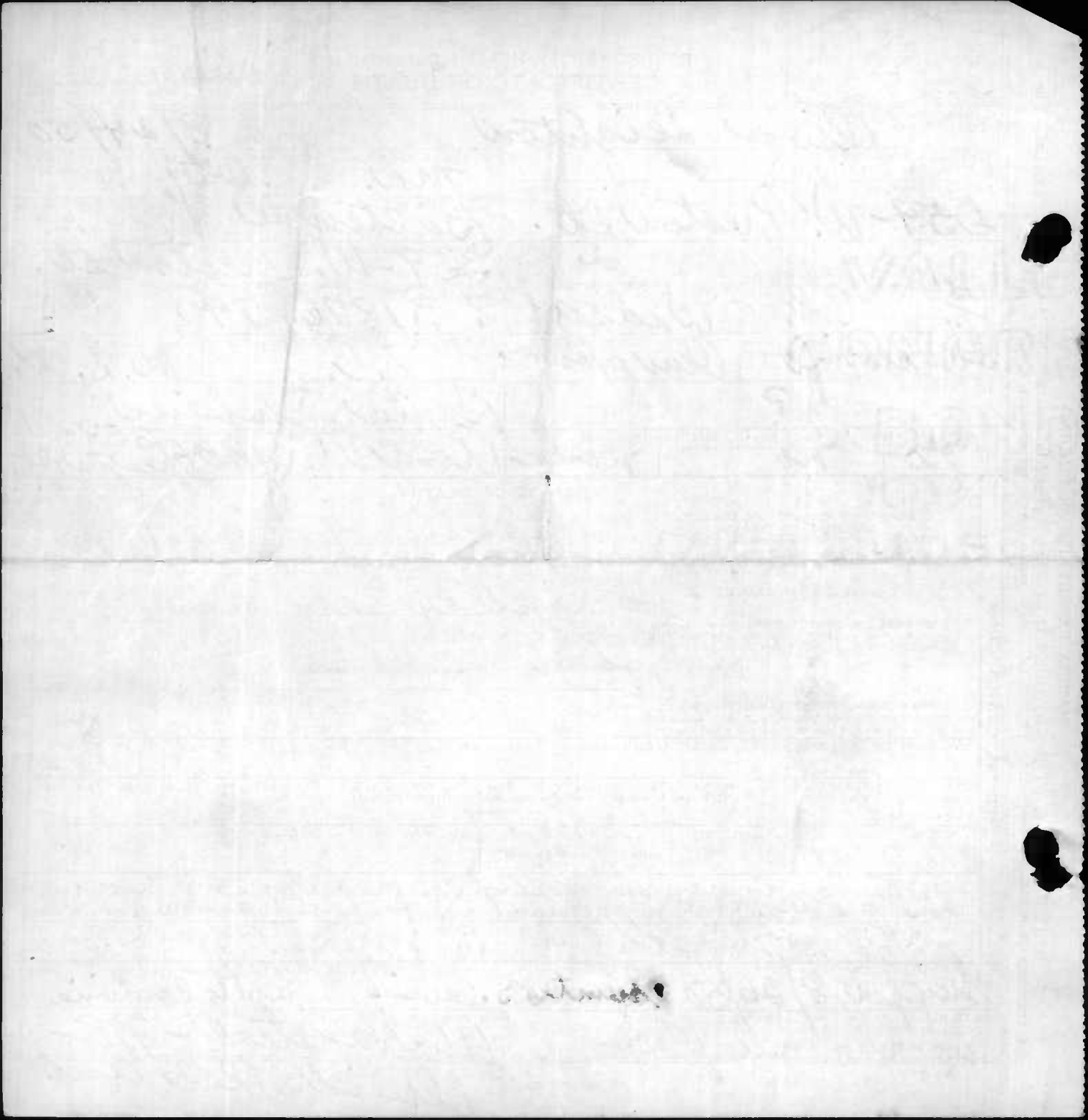
W. Halstead

ADDRESS

918 -

VS 150

0934 Howard Hill Ave.



| | | | | | |
|---|-------------------------------|--|---|--|--|
| B-632 50 7350 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | X 50 7350 Registered No. | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) DONNA RAE BRODOWSKI | | | 2. DATE OF DEATH Aug 24, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD B. COUNTY | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dundalk 53-06 | | |
| c. Length of stay in Baltimore life | | | D. STREET ADDRESS (If rural, give location) 7324 Holabird Ave | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 3-5-49 | 9. AGE (in years last birthday) 1 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME Iwin Brodowski | | | 14. MOTHER'S MAIDEN NAME DOLORES BRODOWSKI | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS | | |
| 18. 204.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 hrs. | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Acute Leukemia DUE TO INTERVAL BETWEEN ONSET AND DEATH 12 wks. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 8/26/50 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 5/31 , 19 50 , to 8/24 , 19 50 , that I last saw the deceased alive on 8/24 , 19 50 , and that death occurred at m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE David M. Smith M.D. | | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | | 23C. DATE SIGNED | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24B. DATE 8/26/50 | | 24C. NAME OF CEMETERY OR CREMATORY Christ Lutheran Church | |
| 24D. LOCATION (City, town, or county) Dundalk, Md. | | 24E. GENERAL DIRECTOR HENRY SANDER & SONS, INC. | | 24F. ADDRESS BALTO., 13, MD. | |
| DATE RECEIVED BY AUG 25 1950 | | REGISTRAR'S SIGNATURE David M. Smith | | ADDRESS See J. Sander | |
| VS 150 DAVID M. SMITH 074.1 | | | | | |

THE UNIVERSITY OF CHICAGO
LIBRARY

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1999-00

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7351

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HANNAH A. KRAUSE

2. DATE
OF
DEATH

Aug. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, R institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1829 N. Wolfe Street

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1829 N. Wolfe Street

c. Length of stay in Baltimore

31 yrs. Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 12, 1882

9. AGE (in years

last birthday)

67

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Phila., Pa.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Doyle

14. MOTHER'S MAIDEN NAME

Johannah Crowe

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT 1829 N. Wolfe Street
Mr. Wm. C. Krause

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Cerebral Hemorrhage
DUE TO w/h right hemisphere(B) Generalized arterio
DUE TO sclerosis of Cardiac

(C) Hypertrophy

INTERVAL BETWEEN
ONSET AND DEATH

2 days

28 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1922 to Aug 24, 1950, that I last saw the
deceased alive on Aug 23, 1950, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William A. Guaghty

M. D.

23B. ADDRESS

106 E. Biddle St

23C. DATE SIGNED

Aug 25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Memorial Cem. Baltimore, Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William A. Guaghty

25. FUNERAL DIRECTOR

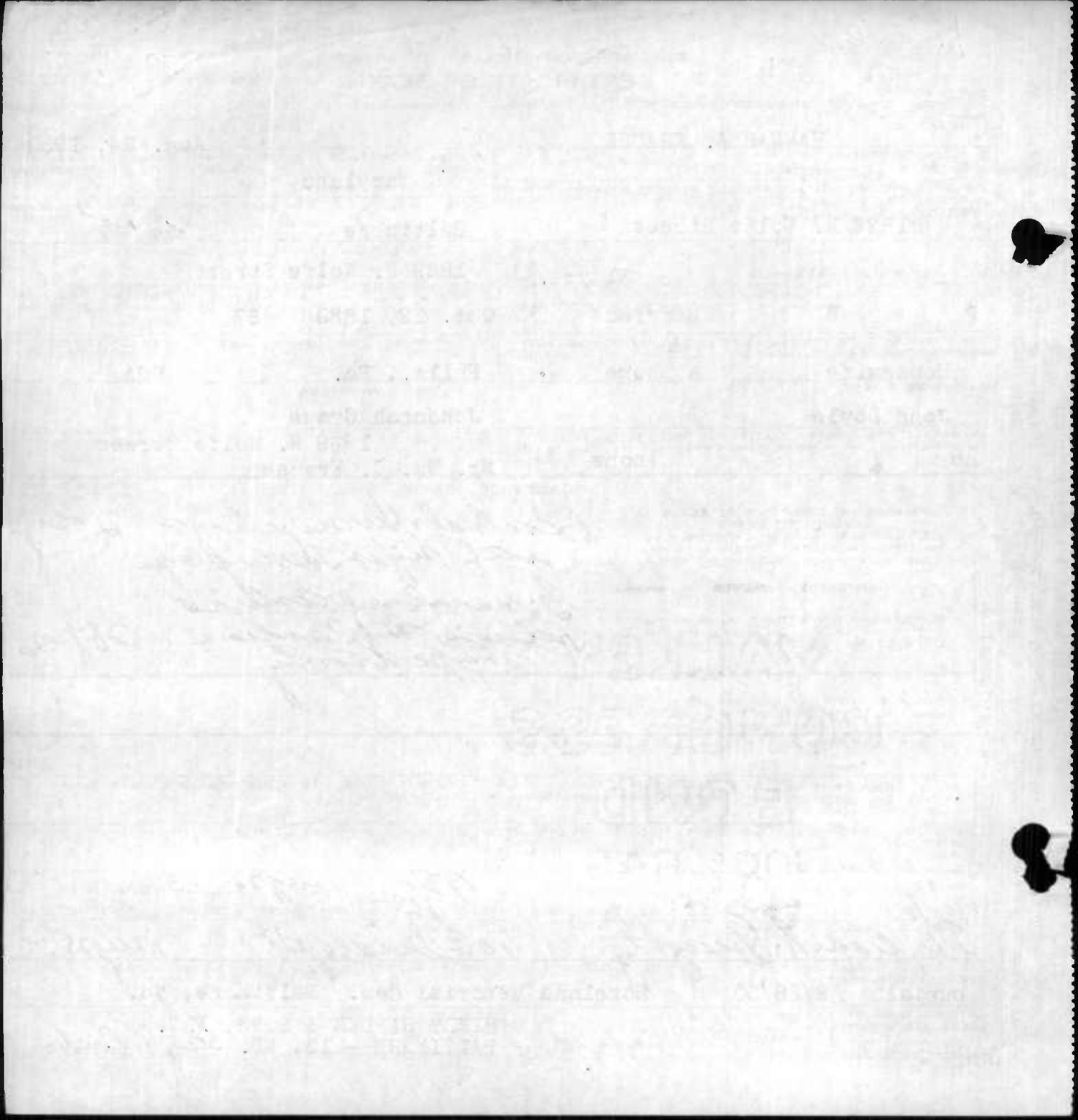
HENRY SANDER & SONS, INC.
BALTIMORE - 13, MD.

ADDRESS

AUG 25 1950
VS 150

Seay P. Sander

093-4



A-645
50 7352

50 7352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

| | | | |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) Emma Amalia Ahrling | | 2. DATE OF DEATH 8-24-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, B. COUNTY Baltimore City | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 835--Brinkwood Rd. | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 28-04 | |
| c. Length of stay in Baltimore life | | D. STREET ADDRESS (If rural, give location) 835 Brinkwood Road-29 | |
| 5. SEX f | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single | 8. DATE OF BIRTH 8-14-1888 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary | | 10B. KIND OF BUSINESS OR INDUSTRY Monitor Controller CO | 9. AGE (In years last birthday) 62 |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George D. Ahrling | | 14. MOTHER'S MAIDEN NAME Emma F. Weinreich | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-01-5225 | |
| 17. INFORMANT George C. Ahrling, 835 Brinkwood Road | | ADDRESS | |

| | | |
|---|--|--|
| 18. 170x, DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO | CAUSE OF DEATH (A) Generalized carcinoma of her osseous system | INTERVAL BETWEEN ONSET AND DEATH 2 yrs |
| | ANTECEDENT CAUSES (B) Carcinoma of breast | 8 yrs |
| | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | | | | |
|--|---|--|--|---|--|
| 19A. DATE OF OPERATION June '42 | | 19B. MAJOR FINDINGS OF OPERATION removal of breast, report-Carcinoma | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) - | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) - | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY - | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? - | | | |
| 22. I hereby certify that I attended the deceased from June '42 , 19 42 , to 8-24-50 , 19 50 , that I last saw the deceased alive on 8-24-50 , 19 50 , and that death occurred at 3.45 PM , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Thos. C. Blake | | 23B. ADDRESS 422 Med. Arts Bldg. Balto 1 | | 23C. DATE SIGNED 8-25-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24B. DATE 8-28-50 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | 24D. LOCATION (City, town, or county) (State) Balto. Md | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1950 | | REGISTRAR'S SIGNATURE Wm. J. Williams, M.D. | | 25. FUNERAL DIRECTOR Mr. & Mrs. John F. Teufel & Son 5311 Edmondson Ave | |

GETTING OFF THE BUS

VALLEY
COMMITTEES
BOARD
L.S.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7353
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH A. MORSBERGER

2. DATE
OF
DEATH

August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

355 Strickland Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Nov. 14, 1882

9. AGE (In years last birthday)

67

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

(Unknown) Massel

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Myrtle V. Cole, 4006 Walrad Ave., Ba

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Compound comminuted fractures of both the

DUE TO right and left tibiae

(B) Crushed chest

DUE TO

(C) Multiple lacerations, abrasions and contusions

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Caton & Strickland St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Aug. 25, 1950

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☐ ASSISTANT MEDICAL EXAMINER.....☒ M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

August 25, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

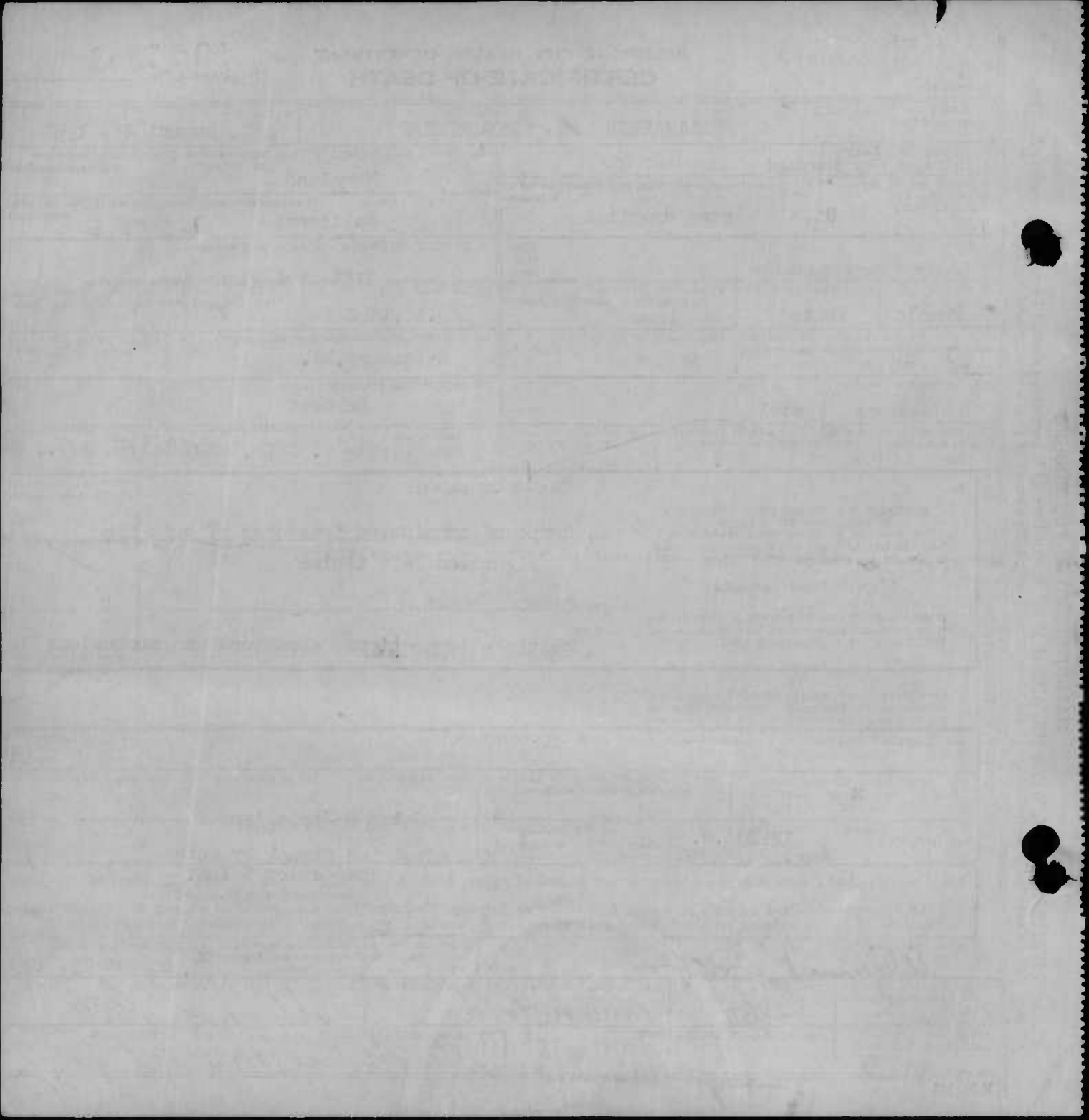
ADDRESS

AUG 25 1950

William V. Smith

1217 St Paul St

170-3



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7354

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

(ANGELINA)ANGELINE BOZZELLI

2. DATE
OF DEATH August 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3915 E. Pratt Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 10, 1892

9. AGE (In years
last birthday)

58

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF
WHAT COUNTRY?
Italy

13. FATHER'S NAME

Ralph Trasatti

14. MOTHER'S MAIDEN NAME

Agatha Santacroce

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Leo Bozzelli 3915 E. Pratt St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Fracture of vertebra and ribs

DUE TO

Ruptured spleen, liver and right kidney
Compound fracture of right leg

(B)

DUE TO

Internal hemorrhage

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)
Street21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
Colgate, Md.
Eastern Blvd. in front of Town Hall21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
August 23, 1950 8:00 P. m.21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

53-00

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
8-24-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

Aug. 26/50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart

24D. LOCATION (City, town, or county)

(State)

Germantown Rd. Dundalk, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

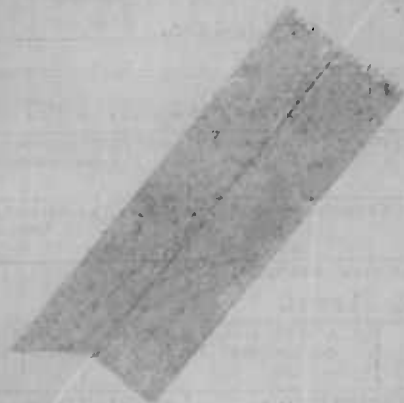
FRANK DELLA NOCE

322 S. High Street

VS 151

N- 805.2

170-3



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7355
Registered No.

BIRTH NO. 50 7355

| | | | | | |
|---|------------------------------|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) <i>Rev. Henry L. Brianceau</i> | | | 2. DATE OF DEATH <i>8-23-1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Md.</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>F. V. A.</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-13</i> | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) <i>Roland Park (St. Mary's Seminary)</i> | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S</i> | 8. DATE OF BIRTH <i>11-23-74</i> | 9. AGE (In years last birthday) <i>75</i> | 10. Under 1 Year Months Days 11. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clergyman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>FRANCE</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Henry T. Brianceau</i> | | 14. MOTHER'S MAIDEN NAME <i>Louise T. Belcot</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Rev. Raymond Meyer, Roland Park</i> | |

| | | |
|--|---|----------------------------------|
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of bladder</i> | CAUSE OF DEATH (A) <i>Carcinoma of bladder</i> DUE TO | INTERVAL BETWEEN ONSET AND DEATH |
| II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Antecedent causes</i> | (B) _____ DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) _____ | |

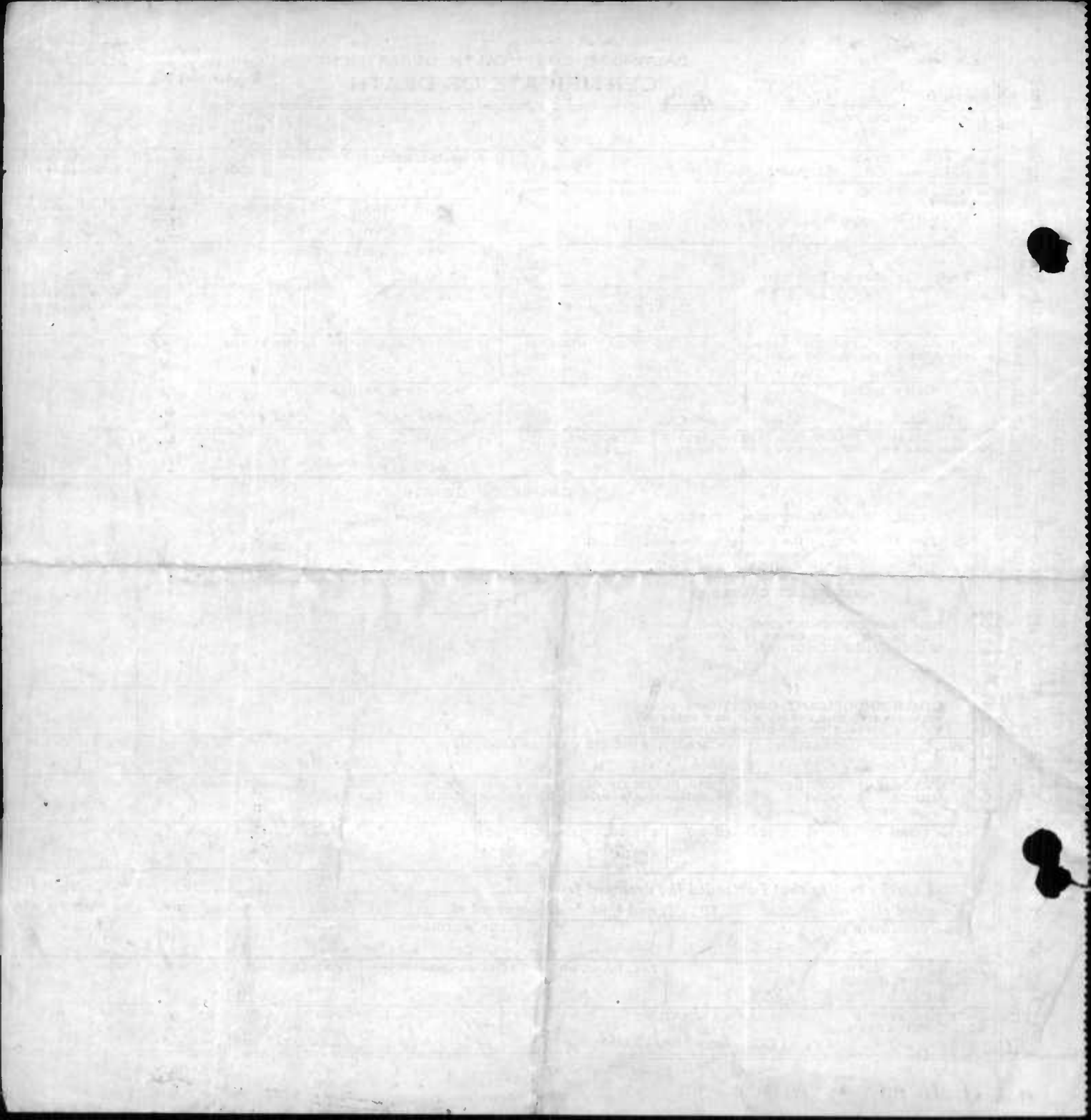
| | | |
|---|---|--|
| 19A. DATE OF OPERATION <i>7-29-50</i> | 19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma of bladder</i> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. | | |
| 23A. SIGNATURE <i>J. Henry</i> | 23B. ADDRESS <i>Bon Secours Hospital</i> | 23C. DATE SIGNED <i>8-23-50</i> |

| | | | |
|--|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>8/26/50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>St. Charles College</i> | 24D. LOCATION (City, town, or county) (State) <i>Catonsville, Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>Aug 25 1950</i> | REGISTRAR'S SIGNATURE <i>William Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>W. W. Meates and Son</i> | ADDRESS <i>805 N. Calverly</i> |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

052-2



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Follmeyer
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7356
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

John Follmeyer

2. DATE
OF
DEATH

8/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4200 Menlo Drive

C. Length of stay in Baltimore

65

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. *002 X I*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *August 16, 1950*, to *August 23, 1950*, that I last saw the deceased alive on *Aug 23, 1950*, and that death occurred at *6:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

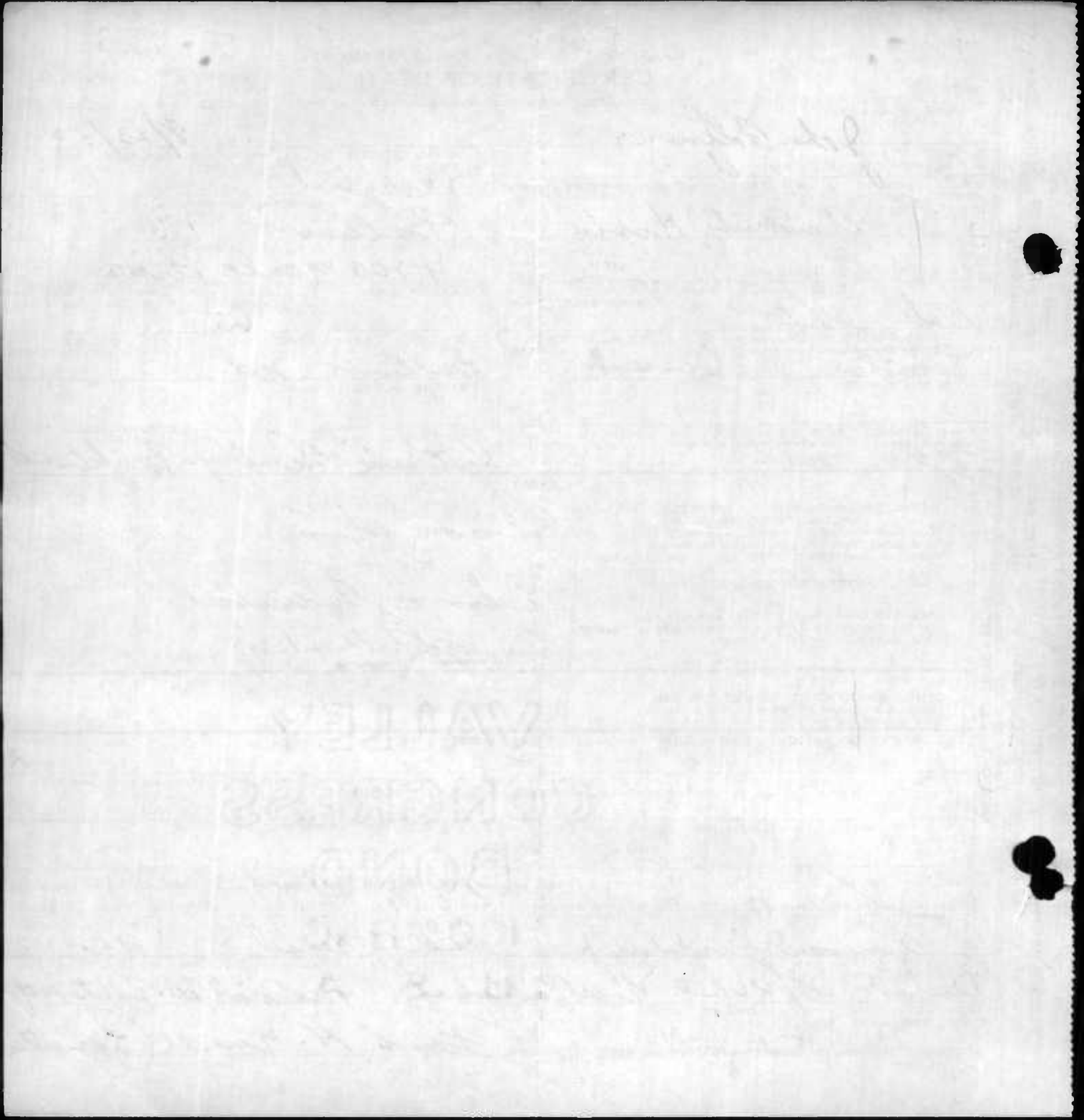
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7357
Registered No. _____

BIRTH NO. 50 7357

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) EMILY L. SHADE | | | 2. DATE OF DEATH Aug. 25, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 531 E. 21st St. | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 531 E. 21st St. | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH Mar. 21, 1866 | 9. AGE (In years last birthday) 84 | If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Elias B. McCartney | | | 14. MOTHER'S MAIDEN NAME Elizabeth Loughner | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mr. C. M. Shade | | | ADDRESS 531 E. 21st St., | | |

| | | |
|---|---|--|
| 18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH: (A) Cerebral Haemorrhage DUE TO (B) Arteriosclerosis Hypertensive DUE TO (C) _____ | INTERVAL BETWEEN ONSET AND DEATH 6 days 5 yrs. |
|---|---|--|

| | | | | | |
|--|---|--|--|--|--|
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 1945 , to Aug. 25th , 1950, that I last saw the deceased alive on Aug. 24th , 1950, and that death occurred at 350 A. M., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Emma E. Cross | | 23B. ADDRESS 38 W. 25th St. | | 23C. DATE SIGNED 8-25-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24B. DATE 8/26/50 | 24C. NAME OF CEMETERY OR CREMATORY Headricks | 24D. LOCATION (City, town, or county) (State) Conemaugh, Pa. | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1950 | REGISTRAR'S SIGNATURE Thurston Williams, M.D. | 25. FUNERAL DIRECTOR Wm. J. Lickner & Sons | | ADDRESS Baltimore, Md. | |

083.1

CONFIDENTIAL

THE OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20530

[Faint, mostly illegible text covering the body of the document, possibly a letter or report. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JOSEPH CARROLL DUNN

2. DATE
OF
DEATH

8-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTO.

9-08

D. STREET ADDRESS (If rural, give location)

500 E. 21ST ST.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

ST. PAUL NURSING HOME

c. Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

1883-

9. AGE (in years last birthday)

66

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

DRAFTSMAN

10B. KIND OF BUSINESS OR INDUSTRY

GORAN CONST. CO.

11. BIRTHPLACE (State or foreign country)

BALTO.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JOSEPH B. DUNN

14. MOTHER'S MAIDEN NAME

ELIZ. A. KELLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

MRS. MARY E. McAFEE - 404 HOLLEN RD

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
carcinoma of mandible.

INTERVAL BETWEEN ONSET AND DEATH
12 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4/1/*, 19*50* to *8/24*, 19*50*, that I last saw the deceased alive on *8/20*, 19*50* and that death occurred at *12:30 Pm.*, from the causes and on the date stated above.

23A. SIGNATURE

E. E. Swarth

23B. ADDRESS

2431 Maryland Ave.

23C. DATE SIGNED

8/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8-26-50

24C. NAME OF CEMETERY OR CREMATORY

CATHEDRAL

24D. LOCATION (City, town, or county)

CITY

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Christington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Heidfeld & Son

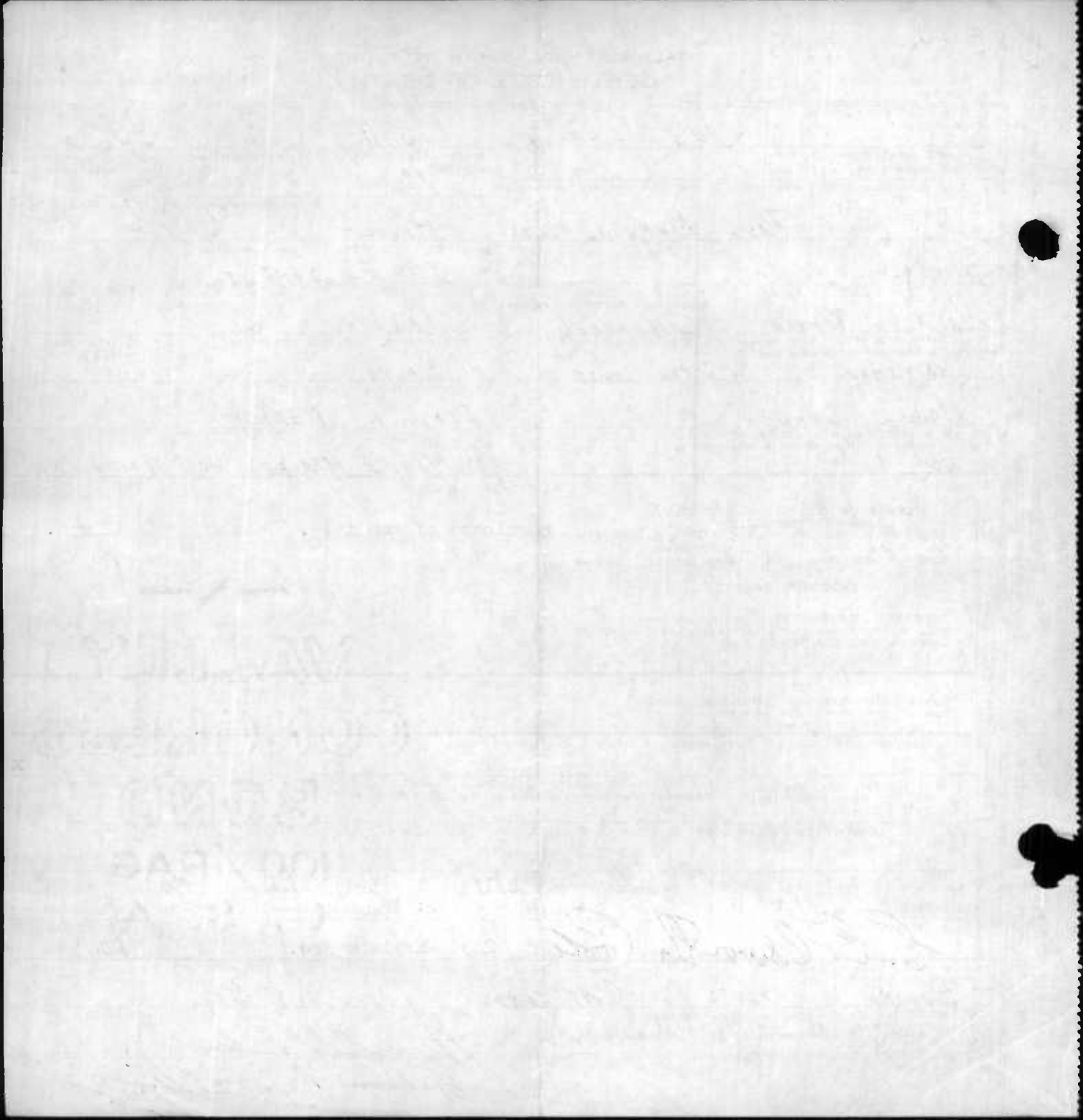
Germantown & 22nd St. 045.4

VS 150

035 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



E-243 50 7359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7359
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK B. EICHOLTZ

2. DATE
OF
DEATH

8/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

9-08

D. STREET ADDRESS (If rural, give location)

2200 Boone St.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

2200 Boone Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

1891

9. AGE (In years
last birthday)

59

If Under 1 Year
Months; DaysIf Under 24 Hours
Hours; Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR
INDUSTRY

self

11. BIRTHPLACE (State or foreign country)

Long Green, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John H. Eicholtz

14. MOTHER'S MAIDEN NAME

Elizabeth Murna

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. F.B. Eicholtz-2200 Boone St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

Coronary Artery Occlusion 15 minutes

Coronary Artery Disease 5 years

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1, 1950, to Aug. 24, 1950, that I last saw the
deceased alive on Aug. 3, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas White

M. D.

23B. ADDRESS

2200 Boone St

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wiedefeld & Son

GREENMOUNT AVE & 22ND

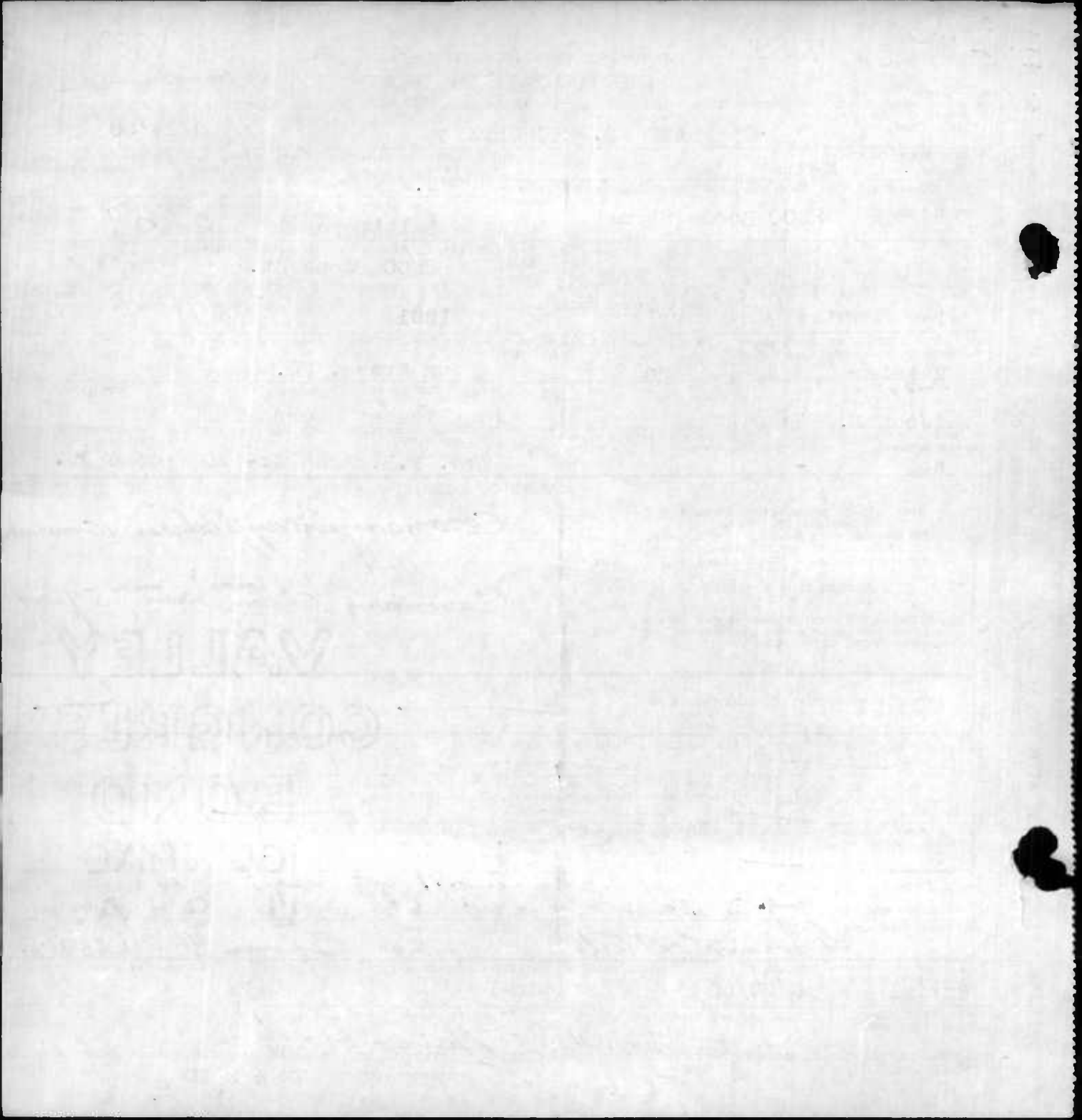
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AUG 25 1950

564 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

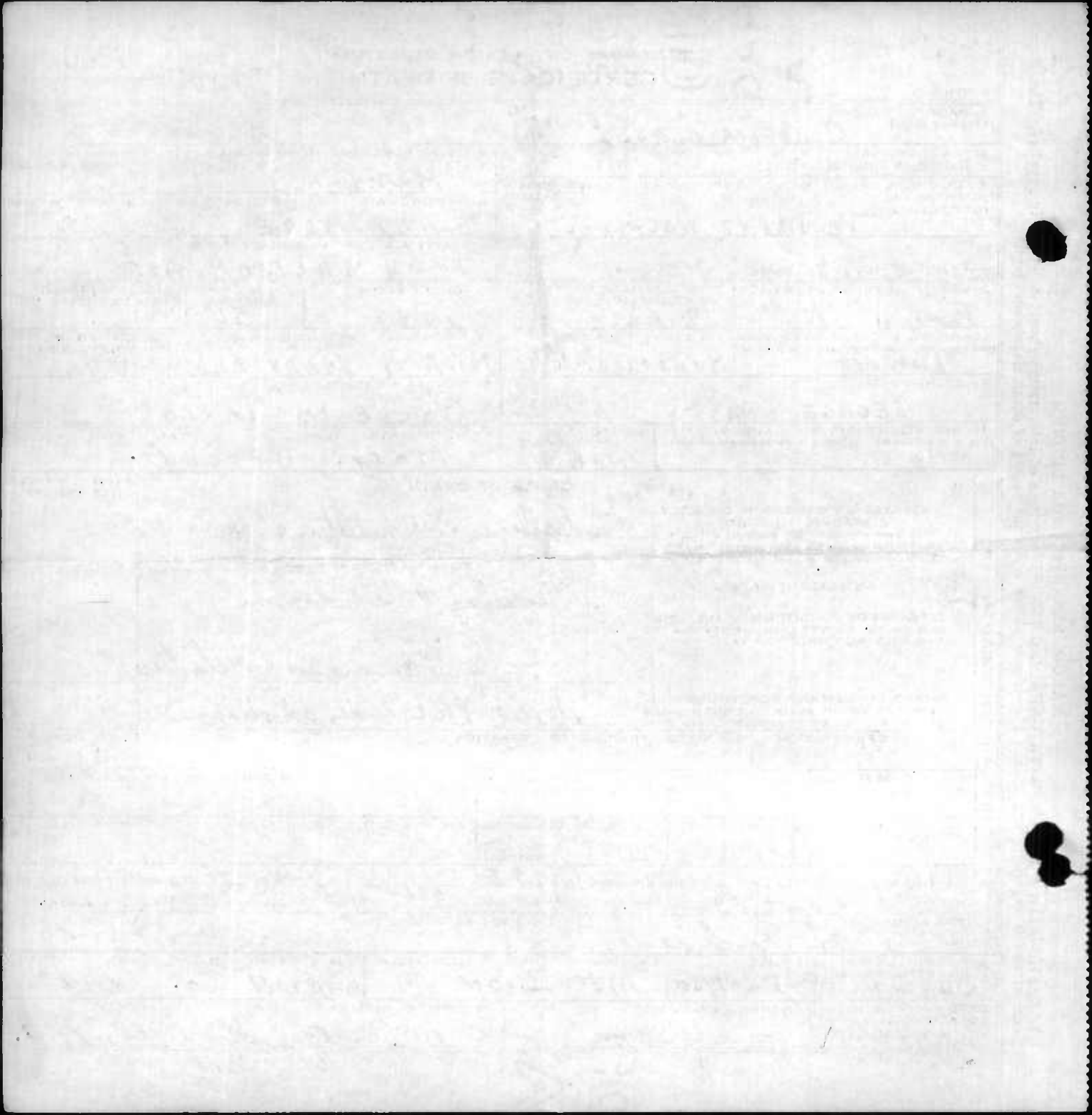


BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7360

BIRTH NO. 50 7360

| | | | | | |
|---|-------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) CORDELIA DORSEY | | | 2. DATE OF DEATH 8-22-50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 14-03 | | |
| c. Length of stay in Baltimore 23 yrs | | | D. STREET ADDRESS (If rural, give location) 1830 MADISON AVE. | | |
| 5. SEX FEMALE | 6. COLOR OR RACE N | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE | 8. DATE OF BIRTH 1899 | | 9. AGE (In years last birthday) 51 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Housework | 11. BIRTHPLACE (State or foreign country) MT. AIRY, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME GEORGE DORSEY | | | 14. MOTHER'S MAIDEN NAME CORDELIA TAYLOR | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT ADDRESS Hosp. Records. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 157X, Coelestia + malnutrition - O.K. Tardie | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST, Generalized Carcinomatosis | | | DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ca of Pancreas + metastases | | | DUE TO | | |
| 19A. DATE OF OPERATION 0 | | | 19B. MAJOR FINDINGS OF OPERATION Healed TBC Nodes at Hilum | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 7-5-50 19, to 8-22-50 19, that I last saw the deceased alive on 8-22-50 , and that death occurred at 8:05 m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE J. H. Pinkney | | | 23B. ADDRESS M. D. | | 23C. DATE SIGNED 8-23-50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 8-26-1950 | 24C. NAME OF CEMETERY OR CREMATORY MT. ZION | | 24D. LOCATION (City, town, or county) (State) CARROLL Co. Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1950 | | REGISTRAR'S SIGNATURE H. H. Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS G. M. Waltz, Winfield, Md. | |



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7361
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELSIE

MORRIS

2. DATE OF DEATH
August 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

616 Bradley St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

4/20/1906

9. AGE (In years last birthday)

44

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

State

12. CITIZEN OF WHAT COUNTRY?
U.S.

13. FATHER'S NAME

Spencer Morris

14. MOTHER'S MAIDEN NAME

Elizabeth Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

J. S. Fisher

23B. CHIEF MEDICAL EXAMINER..... ☒ ASSISTANT MEDICAL EXAMINER..... ☐ M.D. MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

August 24, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Cemetery

24D. LOCATION (City, town, or county) (State)

Morgue - near Chestnut St. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

J. William Wells - Chestnut St. Md.

ADDRESS

V S 151

7208A

093.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF

WASHINGTON, D. C.

REPORT OF THE CHIEF

1914

ANNUAL REPORT OF THE CHIEF OF THE BUREAU OF PLANT INDUSTRY, UNITED STATES DEPARTMENT OF AGRICULTURE, FOR THE YEAR 1914.

REPORT OF THE CHIEF

WASHINGTON, D. C.

1915

ANNUAL REPORT OF THE CHIEF OF THE BUREAU OF PLANT INDUSTRY, UNITED STATES DEPARTMENT OF AGRICULTURE, FOR THE YEAR 1915.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7362

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET McCARTY

2. DATE
OF
DEATH

Aug. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

27 N. Carey St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

709 W. Lombard St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 23, 1874

9. AGE (In years last birthday)

76

If Under 1 Year

If Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At. Home

11. BIRTHPLACE (State or foreign country)

Westminster, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Johanan Myers

14. MOTHER'S MAIDEN NAME

Margaret (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Joseph Myers, 753 W. Fayette St.

18.

443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute Cardiac Dilatation

INTERVAL BETWEEN ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Hypertensive Cardiovascular Disease

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 12, 1950, to Aug 23, 1950, that I last saw the deceased alive on Aug 23, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8/28/50

Meadow Ridge Memorial

Dersey, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 26 1950

Wilmington, Delaware

Cook 1219 5th Ave

3 copy
West Canadian Wildlife
Hydrogen Carbonaceous Resins

253 v. 1, 2, 3
253 v. 2, 3
253 v. 3, 4

253 v. 3
This is the same

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7363

BIRTH NO.

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) WILLIAM E. HARRIS | | | 2. DATE OF DEATH August 25, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| C. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 2812 N. Howard Street | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH Nov. 7, 1895 | 9. AGE (In years last birthday) 54 | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Officer | | 10B. KIND OF BUSINESS OR INDUSTRY Safe Deposit & Trust Co | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME George Harris | | | 14. MOTHER'S MAIDEN NAME Lillian M. Weyer | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO. 213-10-3650 | 17. INFORMANT ADDRESS Edna Mason, 707 East 34th St. | | |

| | |
|--|--|
| 18. 443X | CAUSE OF DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (A) Hemorrhage into left internal capsule with rupture into lateral ventricle |
| | (B) Hypertensive cardiovascular disease |
| | (C) |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |

| | | |
|--|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| | | |
|---|---|------------------------------------|
| 23A. SIGNATURE <i>William V. Smith</i> | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> | 23C. DATE SIGNED 8-25-50 |
|---|---|------------------------------------|

| | | | |
|--|-----------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/28/50 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
|--|-----------------------------|--|--|

| | | | |
|--|--|---|---------|
| DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1950 | REGISTRAR'S SIGNATURE <i>Arthur J. Williams, M.D.</i> | 25. FUNERAL DIRECTOR <i>J. M. Cook Inc 1217 St Paul St</i> | ADDRESS |
|--|--|---|---------|

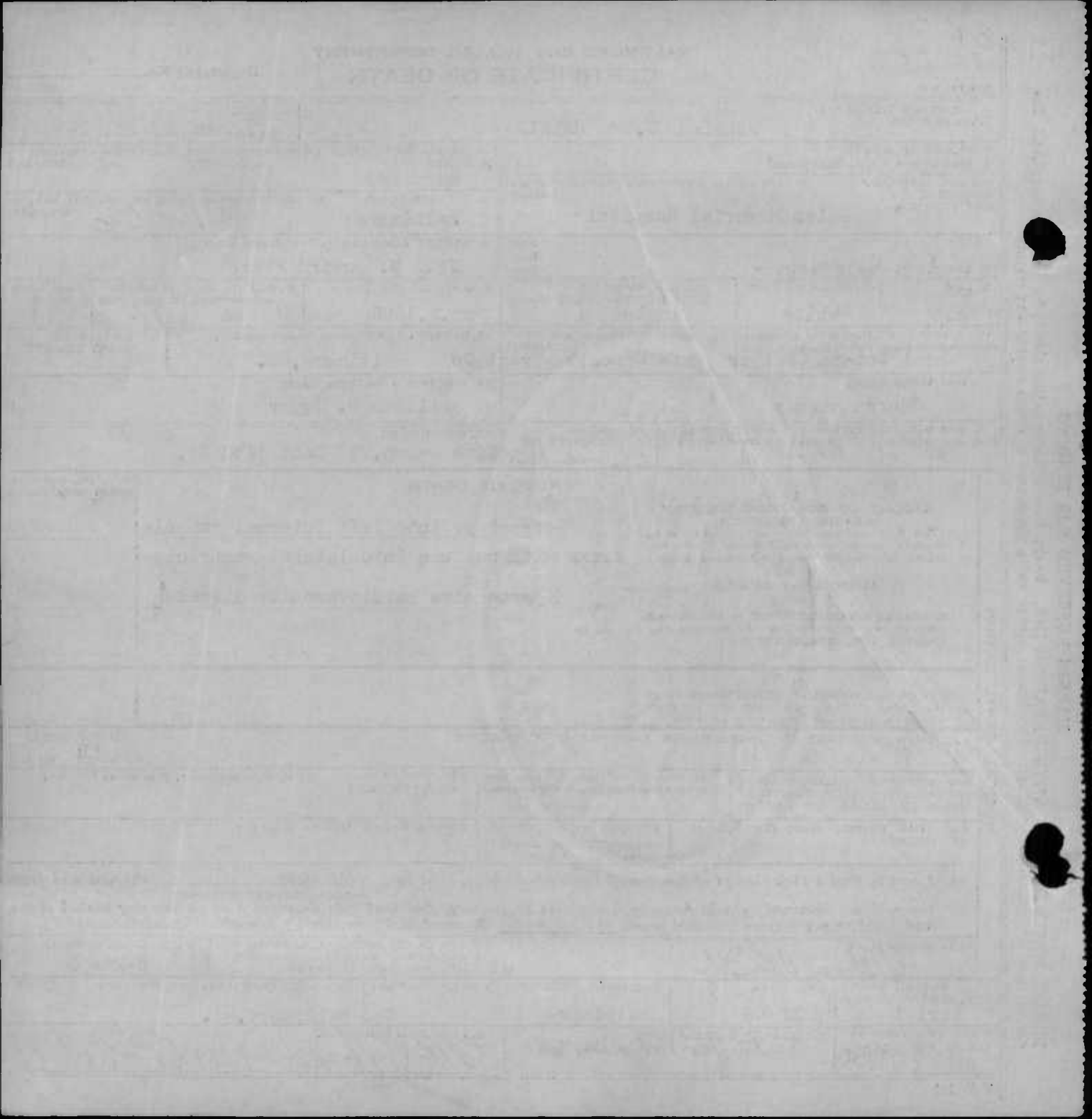
VS 151

47071

093.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7364

BIRTH NO. 50 7364

1. NAME OF DECEASED
(Type or Print)

Edward R. Leight

2. DATE
OF
DEATH

8/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland - Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Union Memorial Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

11-02

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

38 W Biddle St Balto (1)

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov 19, 1886

9. AGE (In years last birthday)

63

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Radio - PRES - Commercial Radio Inst.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Abingdon, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James B Leight (D)

14. MOTHER'S MAIDEN NAME

Elise E Mausdale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

W. W #1

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Norma James, Aberdeen Md.

18.

181X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Ca. of bladder

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *7-21*, 19*50*, to *8-24*, 19*50*, that I last saw the deceased alive on *8-24*, 19*50*, and that death occurred at *6:40* p. m., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

23B. ADDRESS

Union Memorial H.

23C. DATE SIGNED

8-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Abingdon

24D. LOCATION (City, town, or county)

Harford County, Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 26 1950

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc., 1217 St. Paul St

VS 150

(Richard Beach M.D.) 2908V

05212

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
CENTRAL AIR MAIL

15-11

15-11

15-11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 7365

BIRTH NO. 50-80165

| | | | | | |
|---|---------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <u>Leemont Singletan</u> | | | 2. DATE OF DEATH <u>August 24/1950</u> | | |
| 3. PLACE OF DEATH: a. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY | | |
| b. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | d. STREET ADDRESS (If rural, give location) <u>419 East St.</u> | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u> | 8. DATE OF BIRTH <u>1-1-50</u> | | 9. AGE (in years last birthday) <u>7</u> Months: <u>23</u> Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <u>Fred Singletan</u> | | | 14. MOTHER'S MAIDEN NAME <u>Hattie Edwards</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. <u>3400</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.) | | CAUSE OF DEATH | | CERTIFICATION APPROVED BY <u>William J. Lubinski</u> M. D. | |
| ANTECEDENT CAUSES | | (A) <u>Convulsion</u> DUE TO | | CHIEF OR ASST. MEDICAL EXAMINER. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) <u>Recurrent Influenza Meningitis</u> DUE TO | | <u>4 weeks</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) <u>Bilateral Subdural Hematomas</u> | | <u>3 weeks</u> | |
| 19a. DATE OF OPERATION <u>7-19-50</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>7-19-50</u> to <u>8-24-50</u> that I last saw the deceased alive on <u>8-24-50</u> and that death occurred at <u>6:50 PM.</u> from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE <u>Edward W. Winkler</u> M. D. | | 23b. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | | 23c. DATE SIGNED <u>8-25-50</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | <u>August 27, 1950</u> | | <u>St. Mary's Cemetery, A. A. Co. Md.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | FUNERAL DIRECTOR | |
| <u>AUG 25 1950</u> | | <u>Washington Williams, M.D.</u> | | <u>Robert Williams</u> 1575 McElroy St. | |

VS 150

Medical Examiner to approve certificates

C-454
50 7366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7366

Registered No. _____

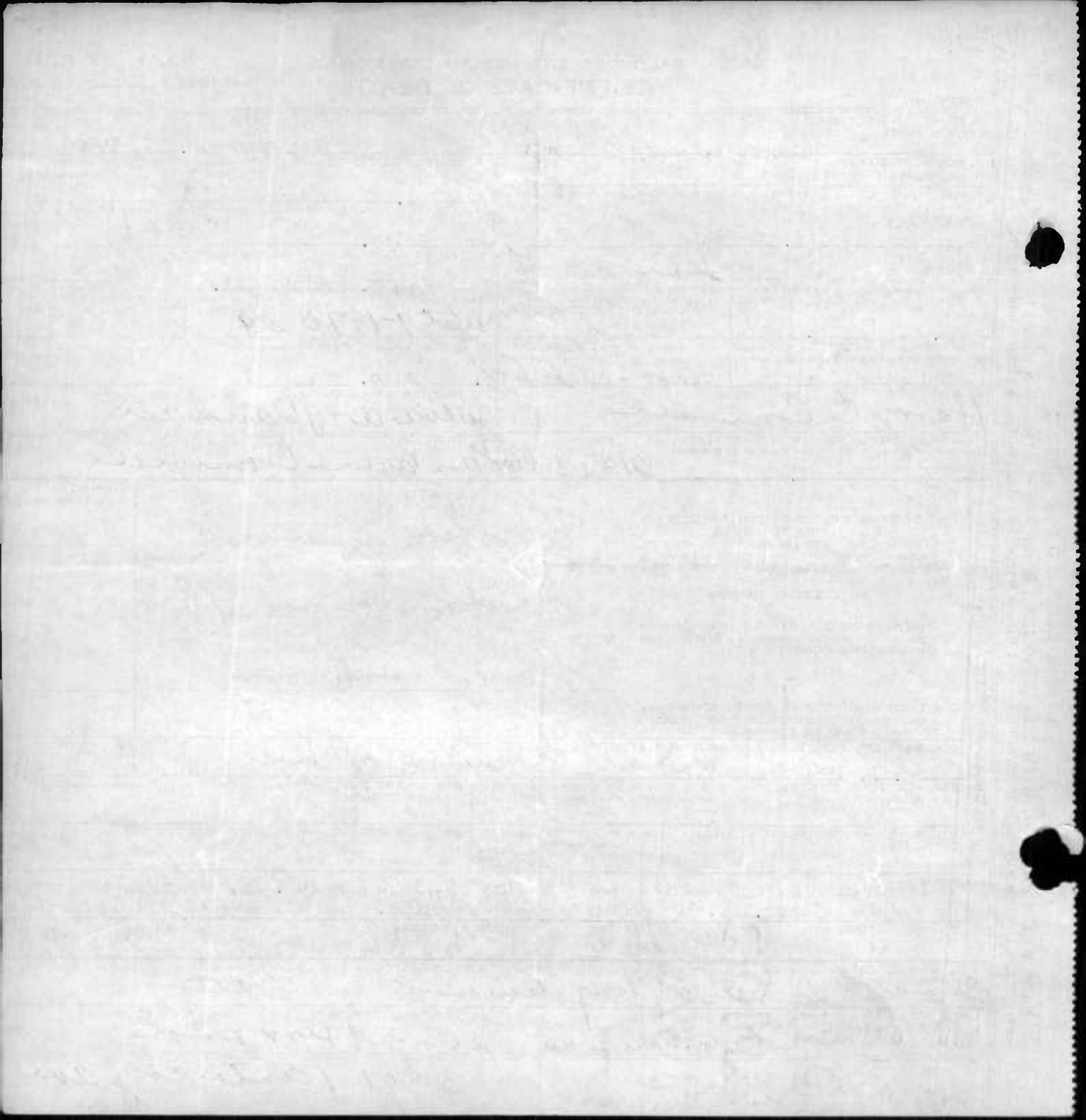
| | | | | | |
|--|----|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| | | Cromwell, Harry Ellsworth | | Aug. 25, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) | | A. STATE | | | |
| St. Joseph's | | Md. | | | |
| C. Length of stay in Baltimore | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| Life | | Balto. | | | |
| 5. SEX | | 6. COLOR OR RACE | | D. STREET ADDRESS (If rural, give location) | |
| M. | W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | | 514 N. Robinson St. | |
| | | Married | | 7-01 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Shipping Clerk | | Warner - Graham & Co. | | Sept 9-1890 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Harry C. Cromwell | | Julia A. - Randall | | 59 | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 213-03-8380 | | Mrs. Pauline Cromwell | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 156.2 | | (A) Hypostatic pneumonia | | | |
| ANTECEDENT CAUSES | | (B) Metastatic carcinoma of liver | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) Primary unknown. | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | |
| Aug. 1, 1950 | | Metastatic carcinoma of liver. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I hereby certify that I attended the deceased from July 19, 1950, to Aug. 25, 1950, that I last saw the deceased alive on Aug. 25, 1950, and that death occurred at 6:05 a.m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE | | 23B. ADDRESS | | 23C. DATE SIGNED | |
| P. J. J. J. J. | | 1400 N. Caroline | | 8/25/50. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Aug 28-50 | | Holy Adeline | |
| 24D. LOCATION (City, town, or county) (State) | | 25. FUNERAL DIRECTOR | | ADDRESS | |
| Baltimore | | J. J. J. J. J. | | 3001 Cantucky ave | |

VS 150

3424R 046.6

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-18770

1. NAME OF DECEASED
(Type or Print)

Baby Girl Ross -

2. DATE
OF
DEATH

8/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

Md. BALTIMORE

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Lutheran Hosp of Maryland

C. CITY OR TOWN

Baltimore 5300

D. STREET ADDRESS (If rural, give location)

1712 Red Oak Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
8 Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8/15/50

9. AGE (In years
last birthday)10. Under 1 Year
Months: Days: Hours: Min.

8

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Vicent Ross

14. MOTHER'S MAIDEN NAME

Lucille Schutte

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Mr Vicent Ross - 1712 Red Oak Rd

18. 759.3

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/15, 1950, to 8/23, 1950, that I last saw the
deceased alive on 8/23, 1950, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

James L. Gray

23B. ADDRESS

Lutheran Hosp. 7 Md.

23C. DATE SIGNED

8/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Aug 25-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balt

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Lutheran Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

J & J Herr & Son

3001, Center city ave

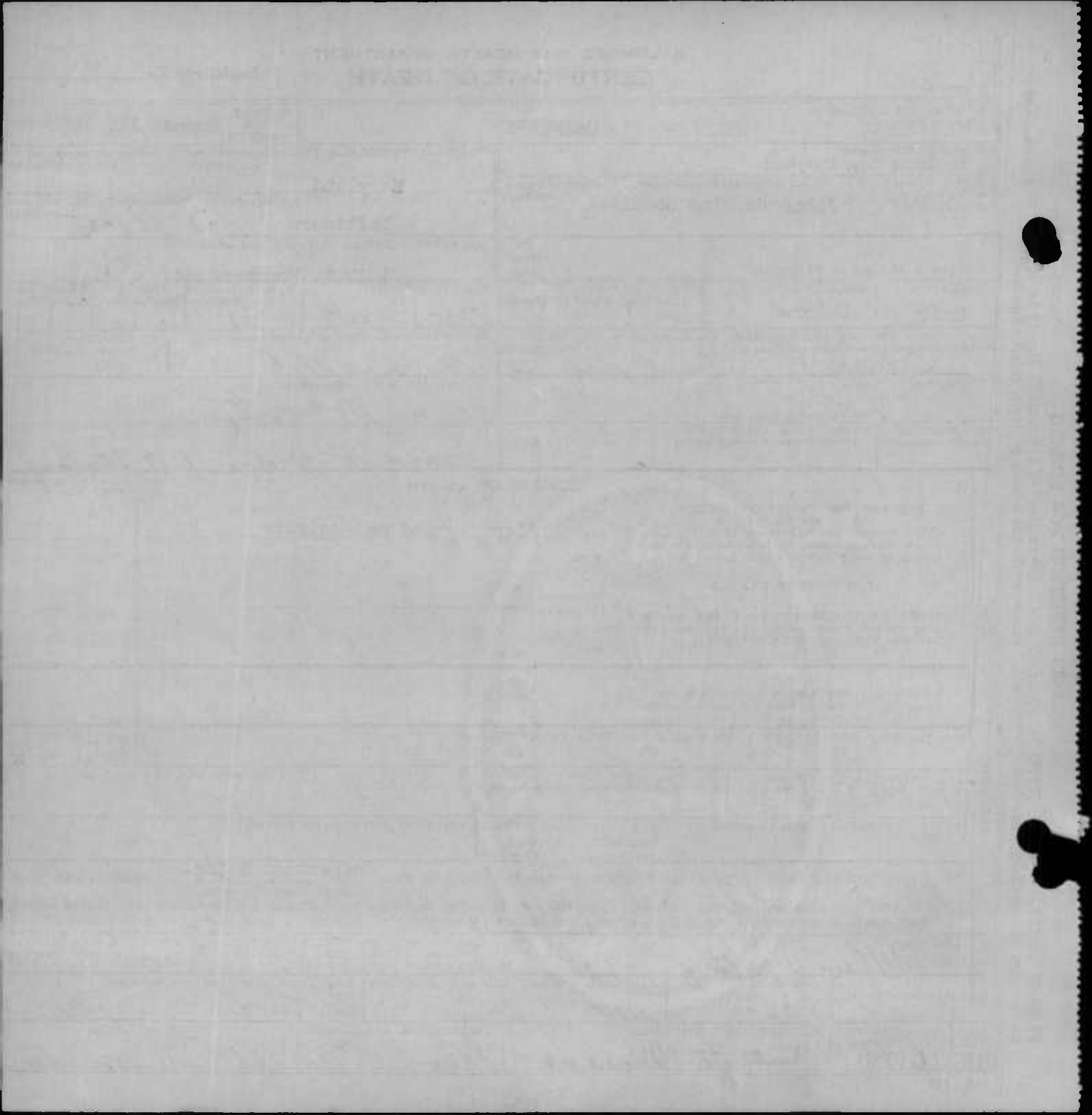
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7368

BIRTH NO.

| | | | | | |
|--|--|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) WILLIAM MCINTYRE | | | 2. DATE OF DEATH August 24, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore | | | D. STREET ADDRESS (If rural, give location) 1017 E. Monument St. | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH Nov 9-1918 | 9. AGE (In years last birthday) 31 | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. man | | 10B. KIND OF BUSINESS OR INDUSTRY Truck Helper | 11. BIRTHPLACE (State or foreign country) Wilson N.C. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Marie McIntyre | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS David McIntyre - 639 Stirling | | |
| 18. 353.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Epilepsy - grand mal seizure DUE TO (A) Epilepsy - grand mal seizure DUE TO (B) DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I took charge of the remains described above, held an Inspection & inq. thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . | | | | | |
| 23A. SIGNATURE William V. Smith | | | 23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR..... | | 23C. DATE SIGNED August 25, 1950 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/26/50 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary | 24D. LOCATION (City, town, or county) (State) A. A. Co. Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1950 | REGISTRAR'S SIGNATURE Wilmington Williams, Jr. | 25. FUNERAL DIRECTOR Mamie W. Wright | | ADDRESS 721 Arguilla | |



MARGIN RESERVED FOR BINDING

PLEASE WRITE CORRECTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R 300
50 7369

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7369

| | | | | | |
|---|----------------------------------|--|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) HANNA E. REED | | 2. DATE OF DEATH Aug. 25, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 4300 Keswick Rd. | | D. STREET ADDRESS (If rural, give location) 4300 Keswick Rd. | | C. Length of stay in Baltimore Yrs. Mos. Days | |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow | 8. DATE OF BIRTH Sept. 13, 1864 | 9. AGE (In years last birthday) 84 | 10 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Michigan | |
| 13. FATHER'S NAME John A. Stuart | | 14. MOTHER'S MAIDEN NAME Henrietta | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) - | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. J. Stuart Reed 4300 Keswick Rd. | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Cerebral Vascular Accident (Stroke) DUE TO (B) Generalized Arteriosclerosis DUE TO (C) Cerebral Thrombosis Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs. 10 days 5 yrs. | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 3rd, 1948 to August 25, 1950 that I last saw the deceased alive on August 25, 1950 and that death occurred at 10:10 am from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE H. M. Primack | | 23B. ADDRESS Emersonian Bldg. | | 23C. DATE SIGNED August 25, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/28/50 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | |
| 24D. LOCATION (City, town, or county) (State) Pikesville, Md. | | 24E. FUNERAL DIRECTOR Wm. J. Lickner Sons | | 24F. ADDRESS Balto Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1950 | | REGISTRAR'S SIGNATURE Washington Williams, Md. | | 25. FUNERAL DIRECTOR ADDRESS | |

James M. Smith
Secretary of the
Board of Directors
of the
First National Bank
of Chicago
Ill.
Dear Sir:

Enclosed for you are
the following checks
for the amount of
\$100.00
Yours very truly,
J. M. Smith

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7370

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ethel E. Wolfe

2. DATE
OF
DEATH

August 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Marlboro Apts.**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Maryland**

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

Marlboro Apts. 1700 Eutaw Pl.

C. CITY OR TOWN (If outside corporate limits, write U.S. and give township)

Baltimore, Md.

D. STREET ADDRESS (If rural, give location)

1700 Eutaw Place.

c. Length of stay in Baltimore

7 yrs.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 12, 1884

9. AGE (in years last birthday)

66

11 Under 1 Year Months: Days

14

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Exnier

14. MOTHER'S MAIDEN NAME

Mildred -----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Abraham N. Wolfe Marlboro Apts. 3-C

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) ...

DUE TO

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

4 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...

DUE TO

Hypertension

years

(C) ...

Pulmonary Edema

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 1/23/1946 to 8/26/1950, that I last saw the deceased alive on 7/16/1950, and that death occurred at 7:50 m., from the causes and on the date stated above.

23A. SIGNATURE

Samuel Morrison

M. D.

23B. ADDRESS

11 E. Chas St (2)

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

New York,

N.Y.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 26 1950

REGISTRAR'S SIGNATURE

Amington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

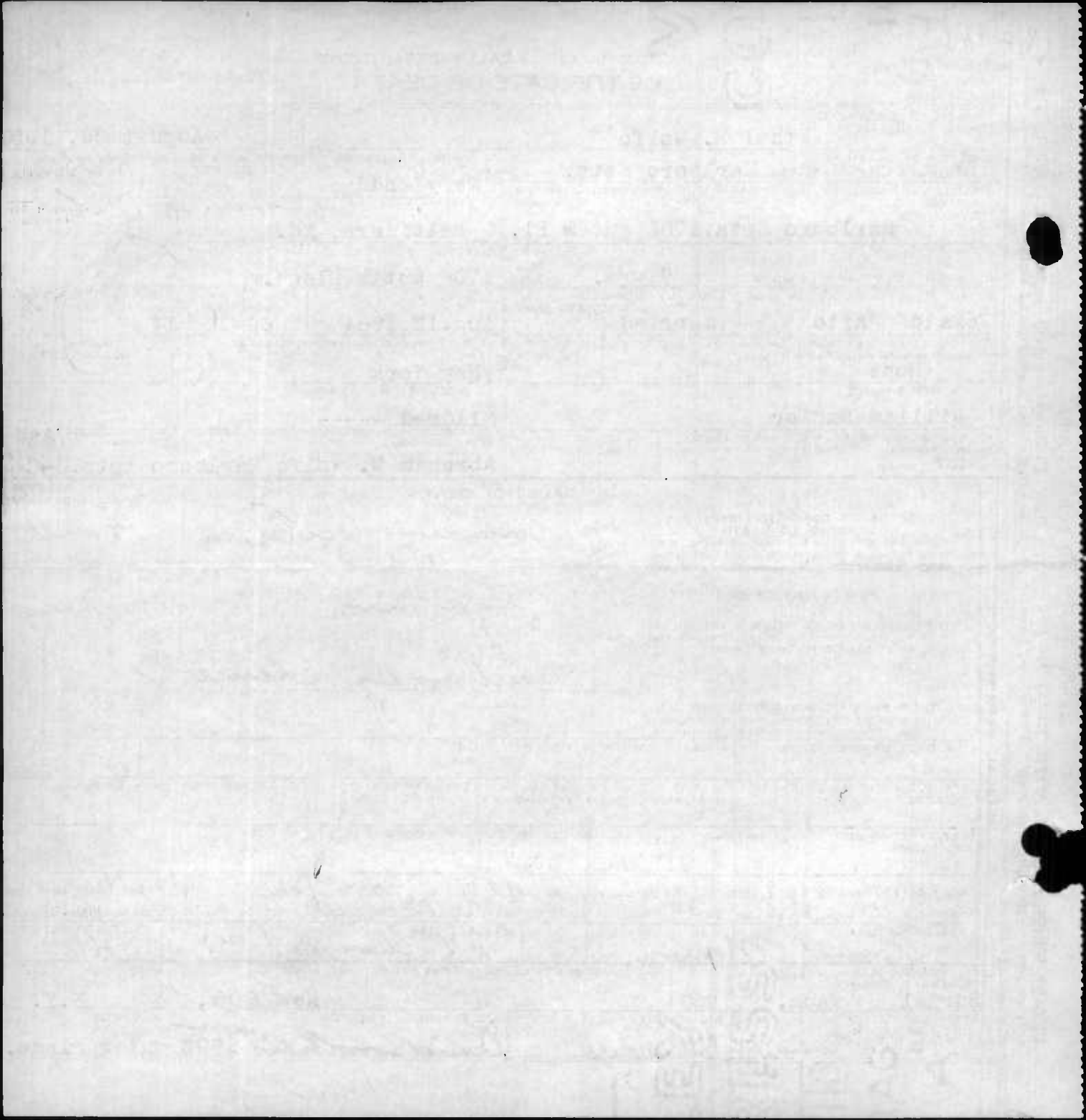
David Sordheim 1902 Eutaw Place.

VS 150

094.1

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE FACTS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

W. 623
50 7371
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7371
Registered No.

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) WILLIAM L. WRIGHT | | | 2. DATE OF DEATH AUG 25, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 808 WELLINGTON ST | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 808 WELLINGTON ST. | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH JAN-24, 1885 | 9. AGE (In years, last birthday) 65 | 10. Under 1 Year Months Days 11. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OPERATOR BALTO TRANSIT | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 13. FATHER'S NAME B. LEE WRIGHT | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | |
| 16. SOCIAL SECURITY NO. | | | 14. MOTHER'S MAIDEN NAME ELIZABETH MILLER | | |
| 17. INFORMANT TERESA M. WRIGHT-808 WELLINGTON | | | ADDRESS ST. | | |
| 18. 002X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 10 Mos. | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Oct 1950 , to Aug 18, 1950 , that I last saw the deceased alive on Aug 15, 1950 , and that death occurred at 1:30 P.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE L. Everett Green | | M. D. | | 23B. ADDRESS Med Anti Bldg | |
| 23C. DATE SIGNED Aug 26, 1950 | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug 28/50 | | 24C. NAME OF CEMETERY OR CREMATORY St. Mary's Hampden - Roland Ave - Md | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | | | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1950 | | REGISTRAR'S SIGNATURE William L. Williams | | 25. FUNERAL DIRECTOR Trustin E. Donovan | |
| | | | | ADDRESS 3818 Roland Ave | |

VS 150

66151

013.2

In J. J. J. J. J.
and Oct 1949.
Room - 521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 7372

BIRTH NO.

50-17645

1. NAME OF DECEASED
(Type or Print)

D'Anna, Vincent

2. DATE
OF
DEATH

Aug. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Md.

B. COUNTY

Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's

C. CITY OR TOWN

Balto.

(If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore

4 da.

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

36 Maryland Ave.

53-00

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 21, 1950

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Salvatore P. D'Anna

14. MOTHER'S MAIDEN NAME

Naomi Ruth Hoxter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 21, 1950 to Aug. 25, 1950 that I last saw the deceased alive on Aug. 21, 1950, and that death occurred at 6:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

1912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

| | | | | | |
|---|----------------------------------|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) GRACE AGNES WARD. | | 2. DATE OF DEATH AUGUST 24 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE CITY. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE CITY. B. COUNTY _____ | | | |
| B. FULL NAME OF (If not in hospital or institution, give street address and location) HOSPITAL OR 4700 HARFORD AVE INSTITUTION HARFORD CONVALESCENCE HOME | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE CITY | | | |
| c. Length of stay in Baltimore LIFE | | D. STREET ADDRESS (If rural, give location) CHARLES & FRANKLINS ST (ROCHAMBEAU) A. | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Jan. 17, 1868 | 9. AGE (In years last birthday) 82 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland. | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Joseph Kelly | | | 14. MOTHER'S MAIDEN NAME Mary Ann Bishop | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS William J. Ward 1 W. Franklin Street | |
| 18. 170 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMIA OF RIGHT BREAST MAY 9 1949 DUE TO (B) METASTASIS TO LIVER. JUNE 1950. DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION MAY 20 1949 | | 19B. MAJOR FINDINGS OF OPERATION CARCINOMIA OF RIGHT BREAST | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from MAY 9 1949 19____, to AUGUST 24 1950 , that I last saw the deceased alive on AUG 24 1950 , and that death occurred at 1 A.M. from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Charles J. Cloutier</i> | | 23B. ADDRESS 3013 ST PAUL STREET | | 23C. DATE SIGNED AUG 24 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/28/50 | | 24C. NAME OF CEMETERY OR CREMATORY Cathedral | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland. | | 25. FUNERAL DIRECTOR ADDRESS H. H. Mead and Son, 805 N. Calvert St. | | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1950 | | REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i> | | VS 150 | |

050.0

REPORT OF SPECIAL AGENT IN CHARGE

DATE OF REPORT

10

REPORT OF SPECIAL AGENT IN CHARGE

DATE OF REPORT

REPORT OF SPECIAL AGENT IN CHARGE

DATE OF REPORT

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REPORT OF SPECIAL AGENT IN CHARGE

DATE OF REPORT

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) *Edward Lawrence Baker*

2. DATE OF DEATH *8/24/50*

3. PLACE OF DEATH:
A. Baltimore City, Maryland *(Home)*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE *Maryland* B. COUNTY *24-06*

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
1253 Knox Ct. KNOX

c. Length of stay in Baltimore *33 yrs*

5. SEX *M*

6. COLOR OR RACE *W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH *July 22, 1917*

9. AGE (In years last birthday) *33 yrs*

If Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) *Baltimore Md. U.S.A.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *Mr. Charles Baker*

14. MOTHER'S MAIDEN NAME *Miss Lillian - Buchanan*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) *Yes*

16. SOCIAL SECURITY NO.

17. INFORMANT *Mrs. Mildred Baker*

ADDRESS *1253 Knox Ct.*

18. *443 X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO *Malignant Hypertensive Cardiac disease*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO *unknown*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *unknown*

INTERVAL BETWEEN ONSET AND DEATH *1 yr.*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Aug. 10, 1950* to *Aug. 24, 1950*, that I last saw the deceased alive on *Aug. 10, 1950* and that death occurred at *2:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE *M. L. Shub*

23B. ADDRESS *1431 Kenhill av*

23C. DATE SIGNED *8/24/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE *8-28-50*

24C. NAME OF CEMETERY OR CREMATORY *Beth.*

24D. LOCATION (City, town, or county) (State) *Baltimore*

DATE RECEIVED BY LOCAL REGISTRAR *AUG 28 1950*

REGISTRAR'S SIGNATURE *W. L. Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS *1305 E. Towson Ave*

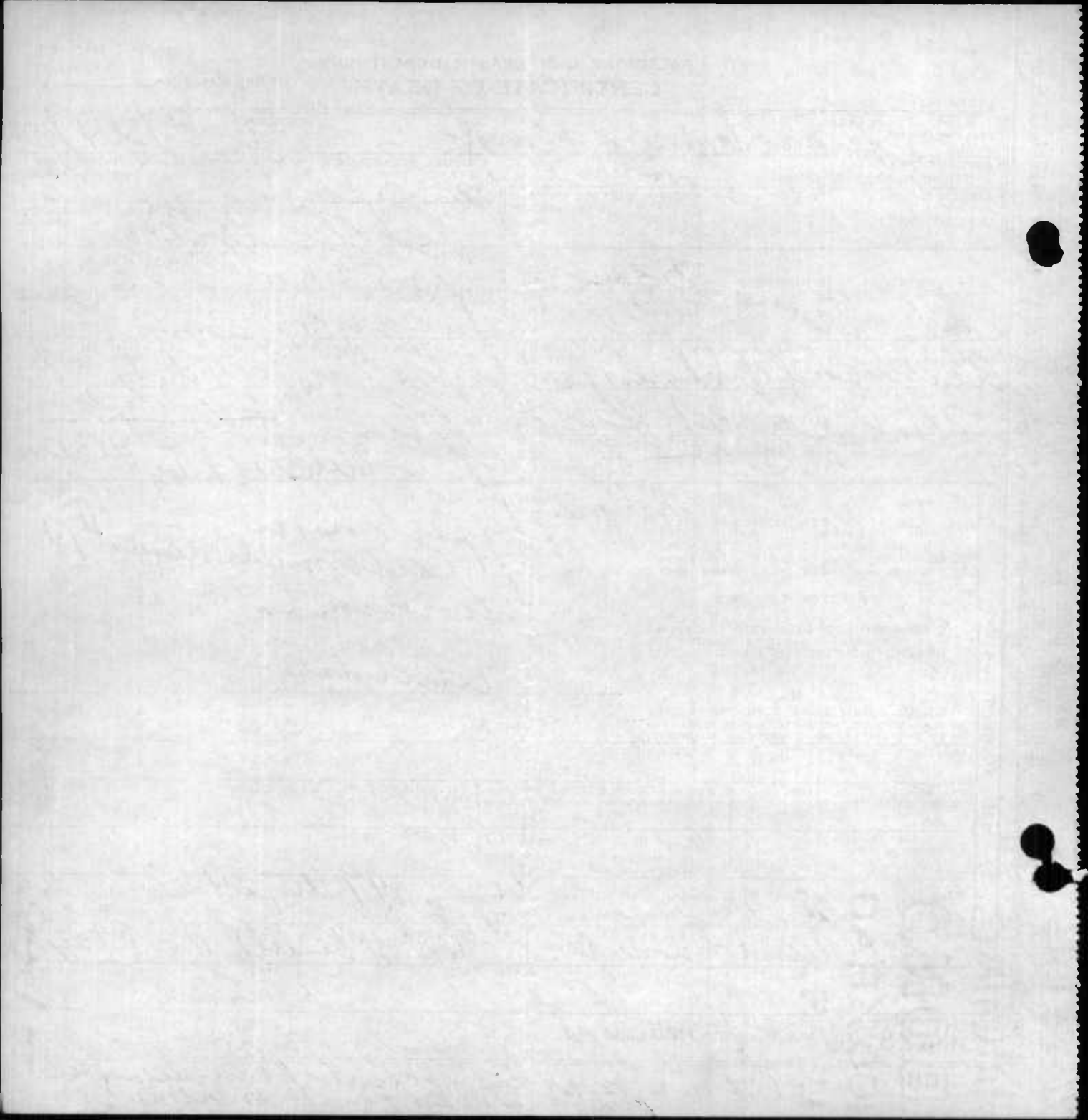
VS 150

69038 (This is Dr. Dialle's patient - I have seen this patient several times in Dr. Dialle's office) 093.4

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7375
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

GRACE M. HACKNEY

2. DATE
OF
DEATH

8/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland **1421 Henry Street**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

(If outside corporate limits, write RURAL and give township)

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

1421 Henry Street

B. FULL NAME OF HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

5/16/1884

9. AGE (In years last birthday)

66

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Annie Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18.

443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial Insufficiency

Arteriosclerosis & Hypertension - Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/10** 19**50**, to **8/23** 19**50**, that I last saw the deceased alive on **8/23** 19**50**, and that death occurred at **11:30 P.M.**, from the causes and on the date stated above.

23. SIGNATURE

John A. Schenck

23B. ADDRESS

1337 S. Charles St.

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

B

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 26 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

James L. Lee

ADDRESS

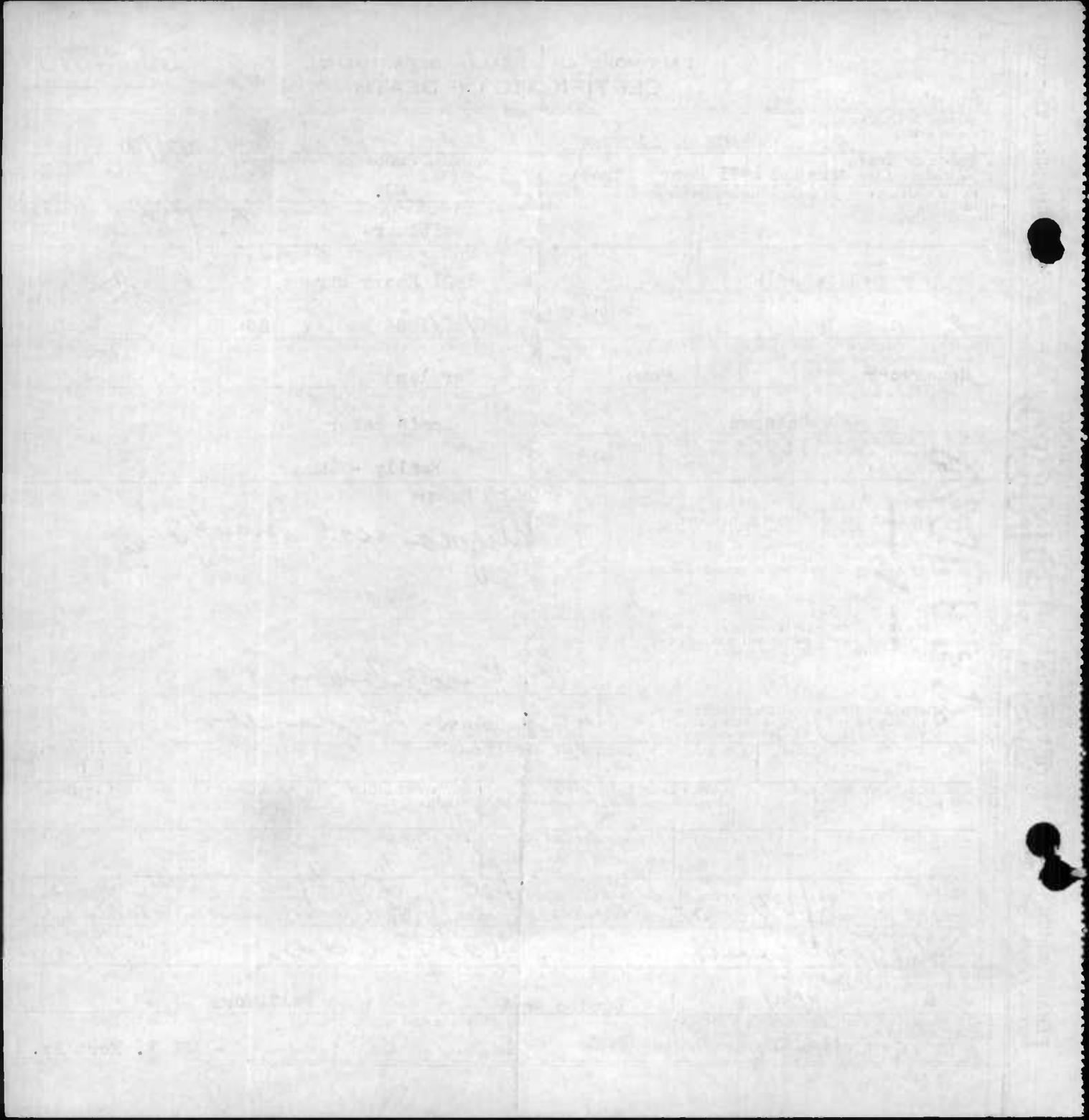
- 130 E. Fort Av.

VS 150

093.4

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7376

BIRTH NO. 50 7376

| | | | | | |
|---|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) BESSIE HELENA FITZGERALD | | | 2. DATE OF DEATH Aug. 25, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3404 Duvall Ave. | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) 3404 Duvall Ave. | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH 9/20/1872 | 9. AGE (in years last birthday) 77 | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At. Home | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Stephen Sweeny | | | 14. MOTHER'S MAIDEN NAME Helen Milliron | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) - | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mr. J. E. Fitzgerald | | |
| | | | ADDRESS 3 Hawthorne Rd., Bronxville, N.Y. | | |

| | | |
|--|--|--|
| 18. 444X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial failure - | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| DUE TO Senility - | | 2 yrs |
| DUE TO Hypertension - | | 10 yrs |
| DUE TO | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. None | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION 0 | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from May - , 19 50 , to Aug. 25 , 19 50 , that I last saw the deceased alive on Aug 24 , 19 50 , and that death occurred at 2 P m., from the causes and on the date stated above. | | |
| 23A. SIGNATURE A. B. McQuane | 23B. ADDRESS 31 E. North Ave | 23C. DATE SIGNED 8.26-50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/28/50 | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Md. Balto Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1950 | REGISTRAR'S SIGNATURE Wm. J. Lickner & Sons | 25. FUNERAL DIRECTOR ADDRESS |

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7377

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES S. KERNELL

2. DATE
OF
DEATH

Aug. 25, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

217 E. 21st St.

Yrs.
Mos.
Days

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

d. STREET ADDRESS (If rural, give location)

217 E. 21st St.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Dec. 2, 1874

9. AGE (In years last birthday)

75

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter (rtd)

10B. KIND OF BUSINESS OR INDUSTRY

Painting

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Kernell

14. MOTHER'S MAIDEN NAME

- Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

Yes--

Spanish American

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mrs. Emma Kernell - 217 E. 21st St.

18. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

24 hrs

4 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 24, 1950, to Aug 25, 1950, that I last saw the deceased alive on Aug 25, 1950, and that death occurred at 2 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas E. Todd

M. D.

23B. ADDRESS

2108 E. Paul St

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 26 1950

REGISTRAR'S SIGNATURE

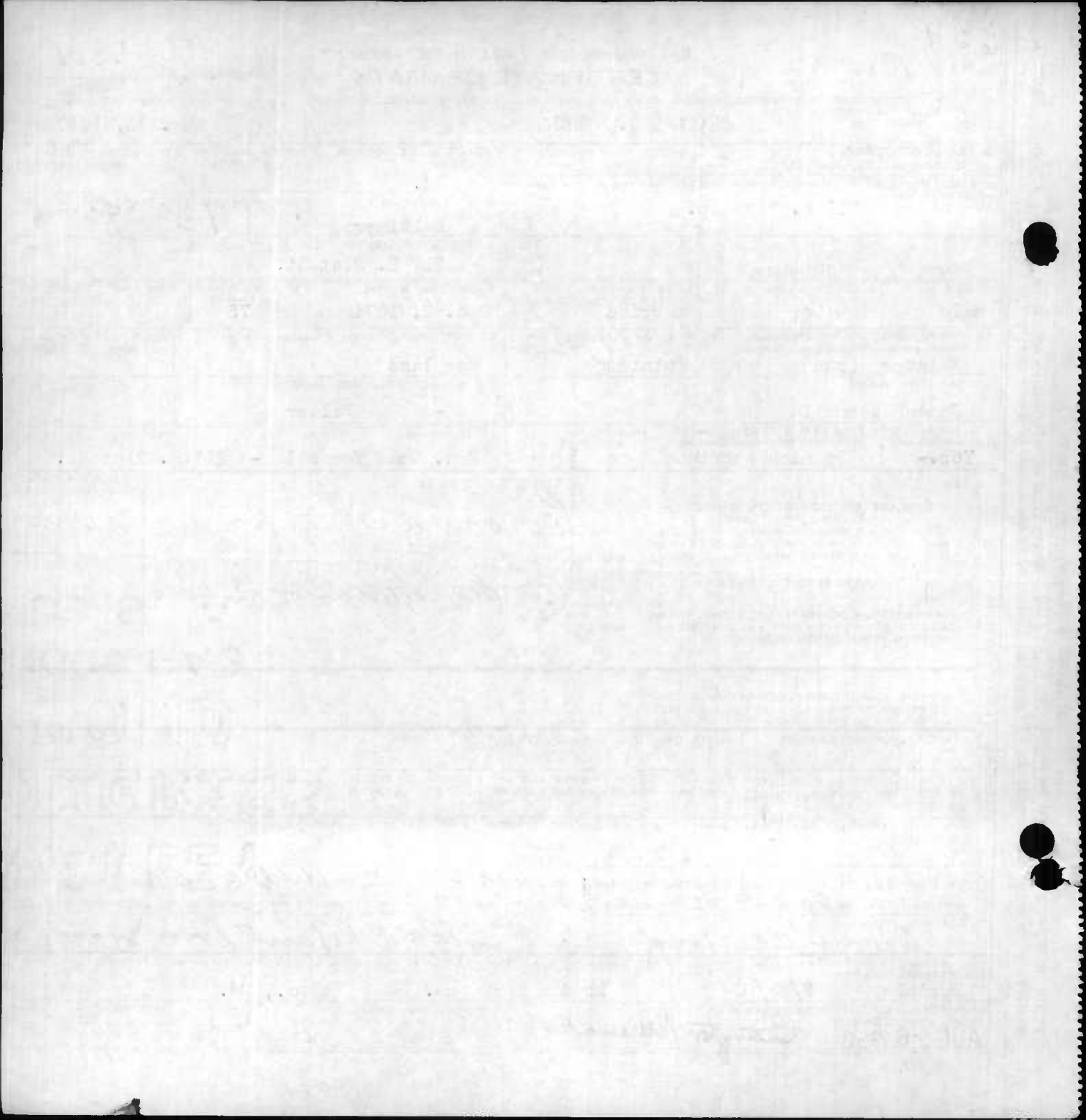
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Thm. J. Lickner & Sons

ADDRESS

Balto Md



CERTIFICATE CORRECTED 8-30-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 7378

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Chase

2. DATE
OF
DEATH

8-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Charles

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Faulkner

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

58-00

5. SEX

m

6. COLOR OR RACE

B

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

m.

8. DATE OF BIRTH

1886

9. AGE (In years last birthday)

64

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

La Plata, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lloyd Chase

14. MOTHER'S MAIDEN NAME

Mary E. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Amelia Chase, Faulkner, Md.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

Respiratory Failure

INTERVAL BETWEEN ONSET AND DEATH

3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Surgical correction of

DUE TO

Gastrojejunal Colic Fistula.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-23-50

19B. MAJOR FINDINGS OF OPERATION

Gastrojejunal Colic Fistula

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER- LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-11, 1950, to 8-26, 1950, that I last saw the deceased alive on 8-26, 1950, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Amelia Chase

23B. ADDRESS

Univ. Hosp. Balt. Md

23C. DATE SIGNED

8-26

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 28 1950

24C. NAME OF CEMETERY OR CREMATORY

St. Thomas

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Hunt & Pagon

ADDRESS

Waldorf Md

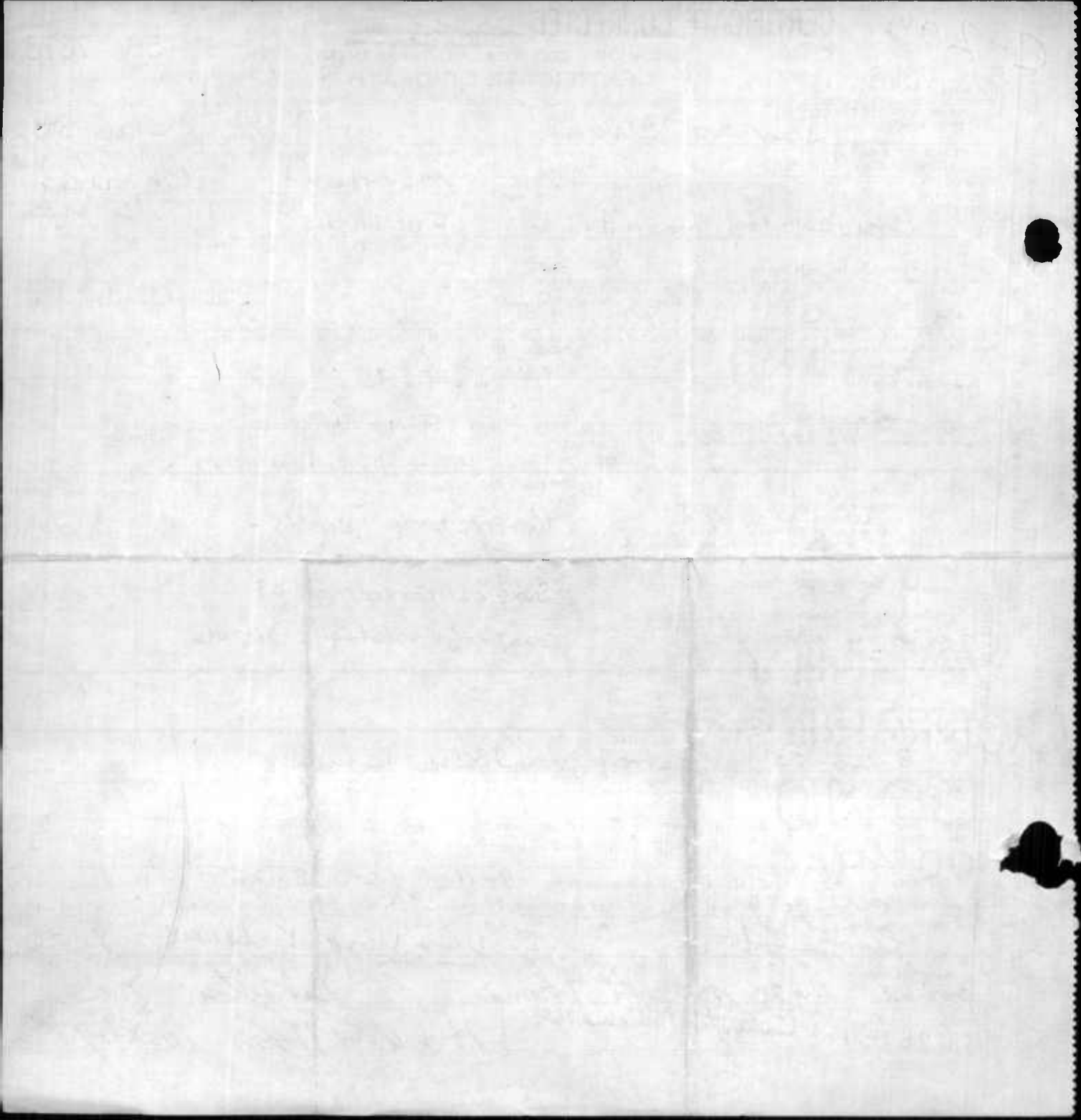
VS 150

97099

118.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)*Thomas Alexander Cox*2. DATE
OF
DEATH*Aug 26-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*701 Beaumont*B. FULL NAME OF
HOSPITAL OR
INSTITUTION*at home*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

CITY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

701 Beaumont Ave

c. Length of stay in Baltimore

10 yrs

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widower

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired

10B. KIND OF BUSINESS OR INDUSTRY

Plumber

8. DATE OF BIRTH

3-19-1876

9. AGE (In years last birthday)

34

11. BIRTHPLACE (State or foreign country)

3rd. U.S.

13. FATHER'S NAME

J. Lee Cox

14. MOTHER'S MAIDEN NAME

May E. Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes Spanish-American War 18-18-1917

16. SOCIAL SECURITY NO.

Misses Cox (sons)

17. INFORMANT

701 Beaumont

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

DUE TO

Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

5 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

*Generalized Arteriosclerosis**2*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

*Cirrhosis of liver**1 yr. 2*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug 21*, 19*50*, to *Aug 26*, 19*50* that I last saw the deceased alive on *Aug 26*, 19*50*, and that death occurred at *9:30 a. m.*, from the causes and on the date stated above.

23A. SIGNATURE

John M. Scott

23B. ADDRESS

8 Longwood Road

23C. DATE SIGNED

Aug 26, '50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial Aug-28**Union Burial Co.**Union Burial Co.**Union Burial Co.**Union Burial Co.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*AUG 26 1950**William Williams, M.D.**Stewart Moore Co.**Balto.*



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 7380**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELSIE DuPleur HEINTZ HEINZ

2. DATE
OF
DEATH

August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Pentwood

HOSPITAL OR INSTITUTION

1324 Penwood Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1324 Penwood Road (Pentwood)

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 15, 1891

9. AGE (In years last birthday)

59

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Leonard DuPleur

14. MOTHER'S MAIDEN NAME

Ida Waltmeyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NONE

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

Mrs. June H. Smith - 2938 St. Paul St. City

18.

581.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Chronic alcoholism**

581.0

ANTECEDENT CAUSES

(B) **Metabolic cirrhosis of liver**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒, **accident** ☐, **suicide** ☐, **homicide** ☐, **undetermined** ☐.

23A. SIGNATURE

William D. Smith

23B. CHIEF MEDICAL EXAMINER.....☐

ASSISTANT MEDICAL EXAMINER.....☒

M.D. MEDICAL INVESTIGATOR.....☒

23C. DATE SIGNED

August 25, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 28, 1950

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park Cemetery

24D. LOCATION (City, town, or county)

Woodlawn, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 26 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Stewart & Mowen Company, 108 W. North Ave.

V S 151

124-2

Balto - 1, 5d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50-7381
50-7381

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARIE E. REHM

2. DATE
OF
DEATH

AUG. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

524 ROSEHILL TERRACE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give
township)

D. STREET ADDRESS (If rural, give location)

800 BELGIAN AVE.

c. Length of stay in Baltimore

LIFE

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

OCT 31, 1887

9. AGE (in year,
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

CLERICAL/STENOGRAPHIC

10B. KIND OF BUSINESS OR
INDUSTRY

B&O R.R.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

JOSEPH M. J. REHM

14. MOTHER'S MAIDEN NAME

MARY FAHEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

705-03-9123

17. INFORMANT

ADDRESS

J. J. REHM 524 ROSEHILL TER.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Terminal Pneumonia

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

36 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Carcinoma left breast with
metastatic carcinoma of spine

DUE TO

3 yrs.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1947

19B. MAJOR FINDINGS OF OPERATION

Adeno Carcinoma

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, to Aug 24, 1950, that I last saw the
deceased alive on Aug 24, 1950, and that death occurred at 6:10 m., from the causes and on the date stated above.

23A. SIGNATURE

E. M. Kayward

M. D.

23B. ADDRESS

132 E 24th St. Balto.

23C. DATE SIGNED

8-25-50

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

BURIAL

24B. DATE

8-28-1950

24C. NAME OF CEMETERY OR CREMATORY

ST. MARY'S GYANS

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 26 1950

REGISTRAR'S SIGNATURE

Thompson

25. FUNERAL DIRECTOR

ADDRESS

H.W. JENKINS & SONS 4905 YORK RD

DR HAYWARD

13 E. EAGER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GUY

FUNKHOUSER

2. DATE
OF
DEATH

August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

131 S. Conkling Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-08

D. STREET ADDRESS (If rural, give location)

103 S. Conkling Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Mar 13 1880

9. AGE (In years last birthday)

70

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR INDUSTRY

Eastern Rolling Mill

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Daniel Funkhouser

14. MOTHER'S MAIDEN NAME

Sarah Hirschberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr Guy Flynn 3508 E Lombard

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. Hirschberger

23B. CHIEF MEDICAL EXAMINER.....☐
M.D. ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED
8-26-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Remove 1
DATE RECEIVED BY
LOCAL REGISTRARAugust 26/50
REGISTRAR'S SIGNATURE

Mt Hebron

25. FUNERAL DIRECTOR

ADDRESS

Winchester Va

AUG 27 1950

9703A

093.4

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

UNITED STATES OF AMERICA
DEPARTMENT OF COMMERCE
BUREAU OF CUSTOMS

WILLIAM
COMPTON
SONS
INC.

C-623
50 7384BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7384
Registered No.

| | | | |
|--|---|--|---|
| BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary Emma Crist</i> | | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i> | | 2. DATE OF DEATH <i>Aug. 25, 1950</i> | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>110 S. Augusta Ave.</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY | |
| c. Length of stay in Baltimore <i>3 1/2 years</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>20-08</i> | |
| 5. SEX <i>Sp.</i> | | D. STREET ADDRESS (If rural, give location) <i>110 S. Augusta Ave.</i> | |
| 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i> | 8. DATE OF BIRTH <i>Mar. 23, 1859</i> | 9. AGE (In years last birthday) <i>91</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homework</i> | | 11. BIRTHPLACE (State or foreign country) <i>MD.</i> | |
| 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Shafston Crist</i> | | 14. MOTHER'S MAIDEN NAME <i>Emma J. Michael</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | |
| 17. INFORMANT <i>Mrs Ethel Brandenburg</i> | | ADDRESS | |
| 18. <i>422.2</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Myocarditis</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Serility</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>Jan 19, 1948</i> to <i>Aug 23, 1950</i> that I last saw the deceased alive on <i>Aug 17, 1950</i> and that death occurred at <i>5:15 p.m.</i> , from the causes and on the date stated above. | | | |
| 23A. SIGNATURE <i>W. L. Garrison</i> | | 23B. ADDRESS <i>4209 Grand Ave.</i> | |
| 23C. DATE SIGNED <i>8-25-50</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | | 24B. DATE <i>8-28-50</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet</i> | | 24D. LOCATION (City, town, or county) (State) <i>Frederick, Md.</i> | |
| DATE RECEIVED BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | |
| 25. FUNERAL DIRECTOR | | ADDRESS | |
| <i>West Hight Funeral Home</i> | | | |
| <i>093.4</i> <i>Shysville, Md.</i> | | | |

STATE OF NEW YORK
DEPARTMENT OF AGRICULTURE

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Meyer Rudolph

2. DATE
OF
DEATH

August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

3401 Denison Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3401 Denison Road

c. Length of stay in Baltimore

60 yrs

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

April 15, 1873

9. AGE (In years,
last birthday)

77

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Tailor L Greif & Bros

10B. KIND OF BUSINESS OR
INDUSTRY

Cloth. Mfg.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Sol Rudolph 3401 Denison Road

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 18, 1948 to 8/25, 1950 that I last saw the
deceased alive on 8/25, 1950, and that death occurred at 5A m., from the causes and on the date stated above.

23. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

Beth Tfiloh Cemetery

24D. LOCATION (City, town, or county)

Windsor Mill Road

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS 1124

L-130
50 7386BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 7386
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ARHIP LEBEDUEW

2. DATE
OF
DEATH

8-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)

A. STATE

B. COUNTY

PENNSYLVANIA

DELANARE

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

U.S. MARINE HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give
township)

CHESTER

D. STREET ADDRESS (If rural, give location)

840 W 5TH ST

C. Length of stay in Baltimore

ONE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

2-14-85

9. AGE (In years
last birthday)

36 yr.

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

BOATWAIN

10B. KIND OF BUSINESS OR
INDUSTRY

SHIPPING

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

NICHOLAS LEBEDUEW

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

190X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

MELANOSARCOMA

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

9 mos

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

SPONTANEOUS PNEUMOTHORAX

36 hrs.

19A. DATE OF OPERATION

8-22-50

19B. MAJOR FINDINGS OF OPERATION

MALIGNANT MELANOMA OF SKIN

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐NOT WHILE ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 26, 1950, to AUG 26, 1950 that I last saw the
deceased alive on AUG 26, 1950, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE

James J. Callaway M. D.

23B. ADDRESS

U.S. Marine Hosp.

23C. DATE SIGNED

8-26-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

8/27/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

Chester, Pa

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John A. Moran, 300 E. Baltimore St

AUG 27 1950
VS 150

67355

053.0

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

NEW YORK
JANUARY 1900

M-244
50 7387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7387
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Eida MacLellan

2. DATE
OF
DEATH

Aug 25-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *3536 Roland Ave*

4. USUAL RESIDENCE (Where deceased lived before admission)
A. STATE *MD*
B. COUNTY *13-06*

B. FULL NAME OF HOSPITAL OR INSTITUTION
00

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

c. Length of stay in Baltimore

30 years

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)
3536 Roland Ave

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Dec 27-1871

9. AGE (In years last birthday)

78

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
house wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
William Winter

14. MOTHER'S MAIDEN NAME
Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT
M. MacLellan

ADDRESS

3332 Elmley Ave

18. *331X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Rt. Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH
10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

10 yrs

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 2, 1950* to *Aug 25, 1950* that I last saw the deceased alive on *Aug 25, 1950*, and that death occurred at *8:35 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE

J. H. Milsau

M. D.

23B. ADDRESS

617 N. 40th St

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 28-50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine

24D. LOCATION (City, town, or county) (State)

Baltimore MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Frank H. Sutz

ADDRESS

814 N. 36th St

AUG 27 1950

083.18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Manner of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Signature of informant: _____

13. Name of informant: _____
14. Address of informant: _____
15. Date of completion: _____

16. Name of registrar: _____
17. Address of registrar: _____
18. Date of completion: _____

19. Name of informant: _____
20. Address of informant: _____
21. Date of completion: _____

22. Name of registrar: _____
23. Address of registrar: _____
24. Date of completion: _____

25. Name of informant: _____
26. Address of informant: _____
27. Date of completion: _____

28. Name of registrar: _____
29. Address of registrar: _____
30. Date of completion: _____

31. Name of informant: _____
32. Address of informant: _____
33. Date of completion: _____

34. Name of registrar: _____
35. Address of registrar: _____
36. Date of completion: _____

37. Name of informant: _____
38. Address of informant: _____
39. Date of completion: _____

40. Name of registrar: _____
41. Address of registrar: _____
42. Date of completion: _____

43. Name of informant: _____
44. Address of informant: _____
45. Date of completion: _____

46. Name of registrar: _____
47. Address of registrar: _____
48. Date of completion: _____

49. Name of informant: _____
50. Address of informant: _____
51. Date of completion: _____

52. Name of registrar: _____
53. Address of registrar: _____
54. Date of completion: _____

J-212
50 7388BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7388

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA JACOBSON

2. DATE
OF
DEATH

8-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year

If Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

ADDRESS

18. 4/20/1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive arteriosclerosis
Cardiovascular diseaseII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/17/1950, to 8/27/1950, that I last saw the deceased alive on 8/27/1950, and that death occurred at 3:40 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY, OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 27 1950

VS 150

Winifred Williams, M.D.

Jack Hewitt

2100 Cutaw PB

094.1

Golombek
3404 Forest Park Ave

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7389
Registered No.

BIRTH NO.

| | | | | | |
|---|----------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MURRILL DOPKIN | | | 2. DATE OF DEATH August 26, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| C. Length of stay in Baltimore Life | | | D. STREET ADDRESS (If rural, give location) 2148 Mt. Royal Terrace | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) 20 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTH PLACE (State or foreign country) Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Philip P Dopkin | | | 14. MOTHER'S MAIDEN NAME Ann | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Philip Dopkin | | |
| | | | ADDRESS Same | | |

| | | |
|--|--|----------------------------------|
| 18. E982X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Stab wound of the heart | | INTERVAL BETWEEN ONSET AND DEATH |
| (A) DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | |
|---|--|---|--|---|
| 19A. DATE OF OPERATION 27 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N.W. corner of North & Charles |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 26, 1950 12:15 Am. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Sharp instrument |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | |
| 23A. SIGNATURE William V. ... | | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> | | 23C. DATE SIGNED August 26, 1950 |

| | | | |
|--|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-27-50 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew | 24D. LOCATION (City, town, or county) (State) Balto Md |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE William V. ... | 25. FUNERAL DIRECTOR Jack Lewis Inc | |
| ADDRESS 2100 Eutan Rd | | | |

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

N-861.2

167.0

G-431
50 7390BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7390

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Samuel Goldberg

2. DATE
OF
DEATH

8/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Sinai

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-03

D. STREET ADDRESS (If rural, give location)

1521 No Bentelows St

c. Length of stay in Baltimore

54

Yrs.

Mons.

Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (In years last birthday)

10

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Grocer

11. BIRTHPLACE (State or foreign country)

Lith

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Tevya

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Rebecca Goldberg

same

18. 331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

INTERVAL BETWEEN ONSET AND DEATH
Aug 25, 1950
Aug 25, 1950

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 25, 1950, to Aug 25, 1950, that I last saw the deceased alive on Aug 25, 1950, and that death occurred at 9:55 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Elmer B. Beingardt

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-27-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (city, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 27 1950

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewis 2100 Central Ave

UNITED STATES OF AMERICA
DEPARTMENT OF COMMERCE
BUREAU OF CUSTOMS AND BORDER PROTECTION



Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)John L. M^s Daniel2. DATE
OF
DEATH

Aug 27-1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

a. STATE

b. COUNTY

Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Franklin Square Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

13-06

d. STREET ADDRESS (If rural, give location)

3330 Chestnut Ave

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

B. DATE OF BIRTH

9. AGE (In years last birthday)

27

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bus Operator

10b. KIND OF BUSINESS OR INDUSTRY

Baltimore Transit Co

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

W. P. M^s Daniel

14. MOTHER'S MAIDEN NAME

Nancy C. R. Burel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. E814-4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Fracture of Skull

DUE TO

Multiple contusions and abrasions

ANTECEDENT CAUSES

(B)

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Bridge

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Carroll Park Bridge & Monroe St.

21d. TIME (Month) (Day) (Year) (Hour)

August 27, 1950 3:05 AM

21e. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

guard rail of bridge
Motorcycle jumped sidewalk and struck

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

William V. Loretto

23b. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐

M.D.

MEDICAL INVESTIGATOR ☐

23c. DATE SIGNED

Aug 27 1950

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

Aug 29/50

24c. NAME OF CEMETERY OR CREMATORY

Rose Wood Cemetery

24d. LOCATION (City, town, or county)

Lewisburg, Pa.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Austin E. Lorcovan

3818 Roland Ave

AUG 27 1950

N-803.2

62551

170D

EXTENDING THE MOUNTAIN TERRITORY
AND INCREASING THE RANCH

John J. McQuinn

1880

1881

1882

1883

1884

1885

1886

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7392
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANCES XAVIER LOGAN

2. DATE
OF
DEATH

August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1637 Ruxton Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

15-03

D. STREET ADDRESS (If rural, give location)

1637 Ruxton Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 28, 1928

9. AGE (In years last birthday)

21

10 Under 1 Year

Months

Days

11 Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Social Security

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Dunaso Logan

14. MOTHER'S MAIDEN NAME

Mary M. Nash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

216-25-5344

17. INFORMANT

ADDRESS

Mrs. Mary Logan 1637 Ruxton Av.

18.

401.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Chronic Endocarditis

INTERVAL BETWEEN ONSET AND DEATH

Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Aug 24/50**, to **Aug 25/50**, that I last saw the deceased alive on **Aug 25/50**, and that death occurred at **10:30 AM**, from the causes and on the date stated above.

23A. SIGNATURE

Henry C. Stouck

M. D.

23B. ADDRESS

1924 W. York Ave

23C. DATE SIGNED

Aug 26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-28-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem

24D. LOCATION (City, town, or county)

Baltimore, Md.

ADDRESS **578 W Biddle St**

DATE RECEIVED BY LOCAL REGISTRAR

AUG 27 1950

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

5. FUNERAL DIRECTOR

Mrs. Frances W. Hendry

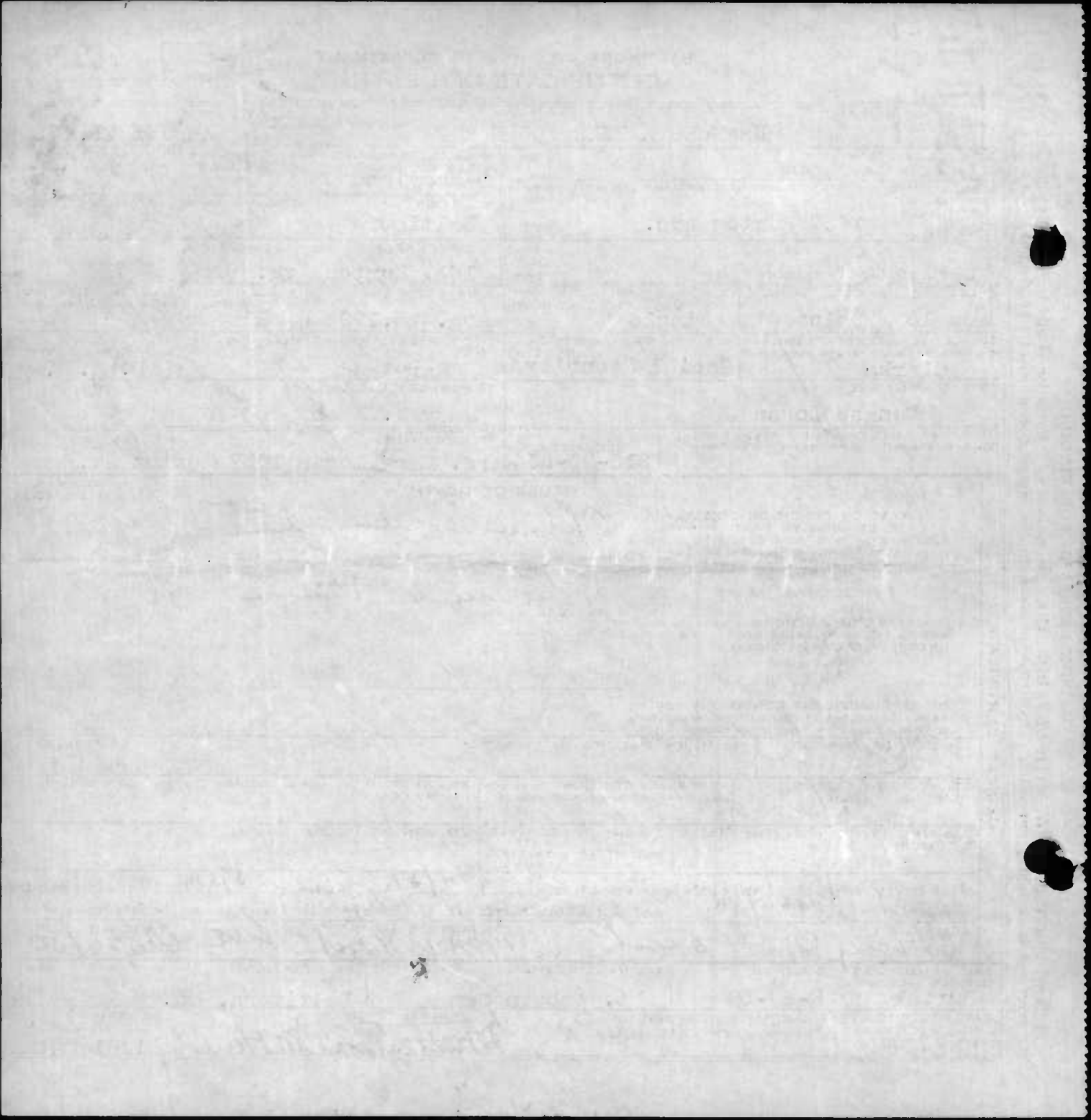
VS 150

390 91

582

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



B-260

BALTIMORE CITY HEALTH DEPARTMENT

X

50 7393

50 7393

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MILTON LEE BAKER

2. DATE
OF
DEATH

Aug 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland HLH 4E

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE NORTH CAROLINA

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

NASHVILLE R.F.D. 3

D. STREET ADDRESS (If rural, give location)

R.F.D. 3

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8-5-50

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

NASHVILLE, TENN.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

CECIL BAKER

14. MOTHER'S MAIDEN NAME

MAMIE POLK

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Cardiac arrest during cyanotic

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) attack
(C) Tetralogy of FallotINTERVAL BETWEEN
ONSET AND DEATHfew minutes
lifeII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-23, 1950, to 8-26, 1950, that I last saw the
deceased alive on 8-26, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Edward Winslow Hopkins

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Removal

24B. DATE

August 27, 50

24C. NAME OF CEMETERY OR CREMATORY

Rocky Mount Cemetery

24D. LOCATION (City, town, or county)

Rocky Mount, N. Car.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Williams Cook & Son, 1217 St. Paul Street

UG 27-1950
VS 150

157e

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. The text appears to be organized into several sections or paragraphs, with some lines being more distinct than others. Faintly visible words and phrases include:

- Top section: "The first of the..."
- Middle section: "The second of the..."
- Bottom section: "The third of the..."

The handwriting is cursive and appears to be from the late 19th or early 20th century. The paper is aged and shows signs of wear, including a large dark stain in the bottom right corner.

H-423

50 7394

HALCOTT

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7394

Registered No. _____

BIRTH NO. _____

| | | | | | |
|---|----------------------------------|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) CHARLES A. HALCOTT | | | 2. DATE OF DEATH 8/25/50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland BALTD. MD. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 4-01 | | |
| c. Length of stay in Baltimore 8 | | | D. STREET ADDRESS (If rural, give location) 311 Cathedral St. | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, <input checked="" type="checkbox"/> MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH Sept 12, 1891 | 9. AGE (In years last birthday) 68 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) Unemployed SEXTON | | | 11. BIRTHPLACE (State or foreign country) NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME CHARLES A. HALCOTT, I. | | | 14. MOTHER'S MAIDEN NAME ELIZA KELLY | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 121-452022 | | 17. INFORMANT Catherine C. Halcott 311 Cathedral St. |

| | | |
|--|---|--|
| 18. 162X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRONCHIOGENIC CARCINOMA | CAUSE OF DEATH (A) BRONCHIOGENIC CARCINOMA DUE TO (B) _____ DUE TO (C) ARTERIOSCLEROTIC C.V.D. | INTERVAL BETWEEN ONSET AND DEATH ? |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | age 20 to 68 |

| | | | | | |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION 8/25/50 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Aug 16, 1950 , to Aug 25, 1950 , that I last saw the deceased alive on Aug 25, 1950 , and that death occurred at 11:00 AM. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE J.S. Kuehn | | 23B. ADDRESS Mercy Hosp. | | 23C. DATE SIGNED Aug 25/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE 25 Aug 1950 | 24C. NAME OF CEMETERY OR CREMATORY Forest Hill | 24D. LOCATION (City, town, or county) (State) Baltimore City, MD | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | REGISTRAR'S SIGNATURE Huntington Williams | 25. FUNERAL DIRECTOR Abella Burke-Bushy | | ADDRESS 1015 North Ave | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

7708W

047.3

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, this 1st day of May, 1900.

Attest my hand and the seal of said County, this 1st day of May, 1900.

Witness my hand and the seal of said County, this 1st day of May, 1900.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7395BIRTH NO. 50 7395

| | | | |
|--|----------------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) <u>Bessie Jones</u> | | 2. DATE OF DEATH <u>August 28, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto Eye, Ear & Throat</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Carroll Co.</u> | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore Eye, Ear & Throat Hospital</u> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Union bridge</u> | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | D. STREET ADDRESS (If rural, give location) <u>Union bridge</u> <u>56-00</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb. 15 1879</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>House wife</u> | 9. AGE (In years last birthday) <u>71</u> If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____ |
| 13. FATHER'S NAME <u>Henry Uterman</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Annie Humbert</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |

| | | | |
|---|---|---|--|
| 18. <u>331 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL HEMORRHAGE</u> DUE TO (A) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>Three days nine hours</u> <u>Several years</u> <u>Three days</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>HYPERTENSION</u> DUE TO (B) _____ | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>DIABETES with Acidosis</u> DUE TO (C) _____ | | | |
| 19A. DATE OF OPERATION <u>August 4, 1950</u> | | 19B. MAJOR FINDINGS OF OPERATION <u>Cataract Right Eye</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Neither</u> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <u>August 7, 1950</u> , to <u>August 28, 1950</u> , that I last saw the deceased alive on <u>August 28, 1950</u> , and that death occurred at <u>5:30 a.m.</u> , from the causes and on the date stated above. | | | |
| 23A. SIGNATURE <u>Henry B. Wilson</u> | | 23B. ADDRESS <u>1214 Eutaw Place, Balto.</u> | 23C. DATE SIGNED <u>August 28, 1950</u> |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 24B. DATE <u>8/30-50</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Lutham Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Uniontown Md</u> |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 28 1950</u> | REGISTRAR'S SIGNATURE <u>Wilmington Williams, Md</u> | 25. FUNERAL DIRECTOR <u>Raymond K. Wright</u> ADDRESS <u>Uniontown Md</u> | |

STATE OF TEXAS

CERTIFICATE OF DEATH

County of _____ State of _____

Deceased _____

Age _____ Sex _____

Married _____

Occupation _____

Residence _____

Place of death _____

Date of death _____

Time of death _____

Cause of death _____

Signature of physician _____

Signature of coroner _____

Signature of registrar _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

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Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7396

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MINNIE VIRGINIA MARSH

2. DATE
OF
DEATH

26 AUG. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

LUTHERAN HOSP. OF MD.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

COCKEYSVILLE

c. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

MASONIC HOME

53-00

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

17 DEC. 1883

9. AGE (In years
last birthday)

66

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William A Storm

14. MOTHER'S MAIDEN NAME

Emma Grovel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

1000

17. INFORMANT

ADDRESS

Miss Lou L Katman 2509 Colby St

18. 420.0

CAUSE OF DEATH.

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) CARDIAC STANDSTILL

DUE TO

ANTECEDENT CAUSES

(B) ARTERIOSCLEROTIC HEART DIS.

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

PERFORATED DIVERTICULUM, SIGMOID

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 20 AUG. 1950, to 26 AUG. 1950, that I last saw the
deceased alive on 26 AUG. 1950, and that death occurred at 3:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

James J. O'Hare

M. D.

23B. ADDRESS

LUTHERAN HOSP.

23C. DATE SIGNED

26 Aug '50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8/30/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Olivet

24D. LOCATION (City, town, or county)

Baltimore MD

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 28 1950

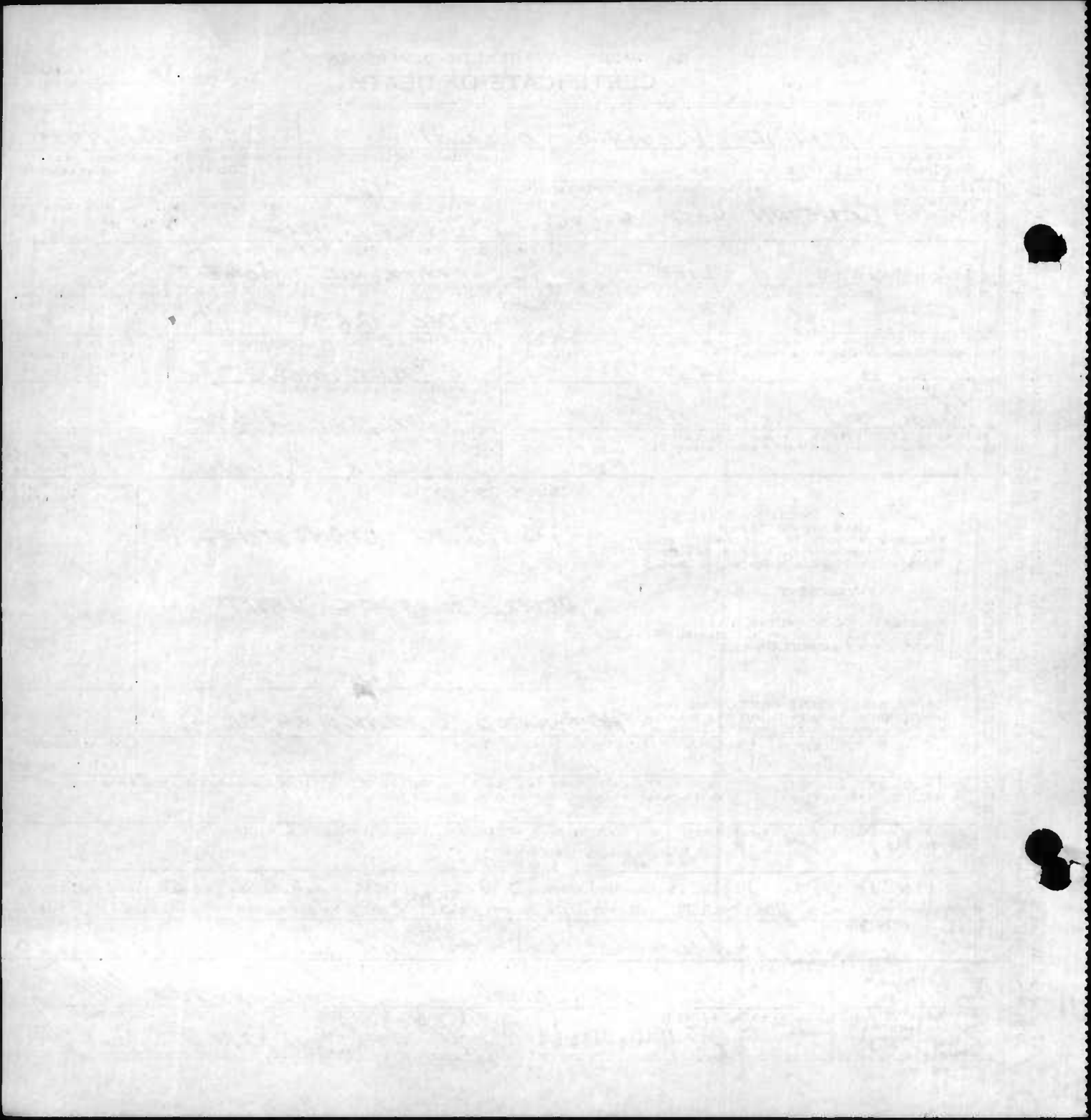
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1211 St Paul St



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7397

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Olive M. Haines (HAINES)

2. DATE
OF
DEATH

26. Aug 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 27. N. CAREY ST

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTIONGood Samaritan Hospital
27. N. CAREY ST. BALTO 23 MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. 13-06

D. STREET ADDRESS (If rural, give location)

3549 Keswick Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

5/3/1890

9. AGE (In years,

last birthday)

60

10. Under 1 Year

Months Days

11. Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Miss Page Co. Va.

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

George Howell

14. MOTHER'S MAIDEN NAME

Jane Hefner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

212-28-246 Dorothy Keller 3019 Chestnut Ave

17. INFORMANT

ADDRESS

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Pneumonia

36 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Right Hemiplegia
Hypertensive Cerebrovascular disease

(C) Senility

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/23 1950, to 8/26 1950, that I last saw the deceased alive on 8/26 1950, and that death occurred at 4:00 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Paul R. Ziegler

23B. ADDRESS

3123 Edmondson Ave

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine

24D. LOCATION (City, town, or county)

Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. Cox, Inc. 1217 St. Paul St

ADDRESS

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

ATTORNEY GENERAL

FOR THE YEAR

1899

ALBANY:

1900

PRINTED BY

THE STATE

PRINTING

OFFICE

ALBANY

1900

1900

1900

1900

1900

1900

1900

1900

1900

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7398

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GERTRUDE

MORTON (Moreton)

2. DATE
OF
DEATH

August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

215 W. Chesapeake Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Apr. 25, 1885

9. AGE (In years
last birthday)

65

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk, Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

Cleaning & Clothing

11. BIRTHPLACE (State or foreign country)

Baltimore County, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Smith

14. MOTHER'S MAIDEN NAME

Annie Wampler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Leroy Haile, 415 York Rd. Towson, Md.

18.

E. 900.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of first cervical vertebra

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

215 W. Chesapeake Avenue

21D. TIME (Month) (Day) (Year) (Hour)

August 25, 1950 6:15 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down cellar steps (inside)

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Brant

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

August 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Poplar

24D. LOCATION (City, town, or county)

Baltimore County, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1214 ST Paul ST

VS 151

N-805.0

390 8C

186.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sarah Myers

2. DATE
OF
DEATH

Aug. 25 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1400 W. Lexington St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Aged Women's & Aged Men's Homes

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

O. STREET ADDRESS (if rural, give location)

1400 W. Lexington St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 31, 1871

9. AGE (in years
last birthday)

78

10. Under 1 Year
Months: Days

9

25

11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?
U.S. of America

13. FATHER'S NAME

William Wilson

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

L.H. Reed 1400 W. Lexington St.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) ...
DUE TO

Cerebral Hemorrhage

20 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) ...
DUE TOHypertensive Arteriosclerotic
vascular disease

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1950 to Aug 25, 1950, that I last saw the
deceased alive on Aug 24, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Newland Edward Day

M. D.

4-E-3348 - 18

Aug. 26, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

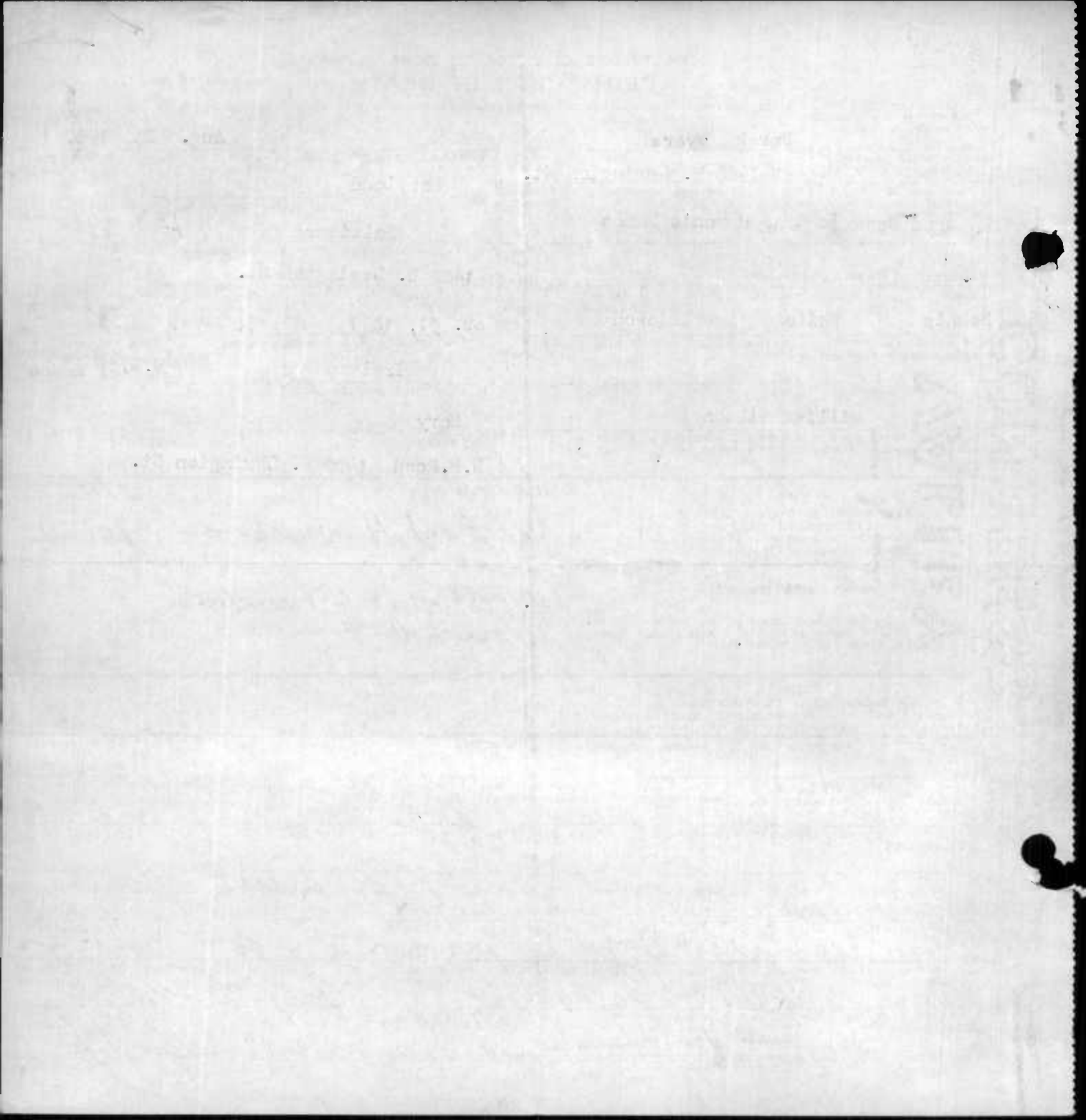
25. FUNERAL DIRECTOR

ADDRESS

AUG 28 1950

Huntington Williams, M.D.

1219 St Paul St



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7400
Registered No. _____

BIRTH NO. _____

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) HARRY McCOMAS | | | 2. DATE OF DEATH Aug. 24, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 1306 N. Enson St. | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) 1306 N. Enson St. | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH June 6, 1865 | 9. AGE (In years last birthday) 85 | 10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stageman, retired | | 10B. KIND OF BUSINESS OR INDUSTRY Theaters | 11. BIRTHPLACE (State or foreign country) Hyde, Md. | | 12. CITIZEN OF WHAT COUNTRY? _____ |
| 13. FATHER'S NAME William McComas | | | 14. MOTHER'S MAIDEN NAME Mary Ann Ladell | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 212-18-0455 | 17. INFORMANT ADDRESS Mrs Emma Foote, 1818 N. Caroline St. | | |

| | | |
|--|--|--|
| 18. 581.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Embolic of the liver DUE TO _____ | | INTERVAL BETWEEN ONSET AND DEATH ? |
| ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO _____ | | |
| (C) _____ | | |

| | | |
|--|---|---|
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardio-vascular renal disease | | |
| 19A. DATE OF OPERATION 0 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on **24 Aug, 1950** and that death occurred at **9:30 p.m.**, from the causes and on the date stated above.

| | | |
|--|--|-----------------------------------|
| 23A. SIGNATURE Samuel H. Luper, M.D. | 23B. ADDRESS 714 E. Preston St | 23C. DATE SIGNED 25 Aug |
|--|--|-----------------------------------|

| | | | |
|--|-----------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/28/50 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
|--|-----------------------------|--|--|

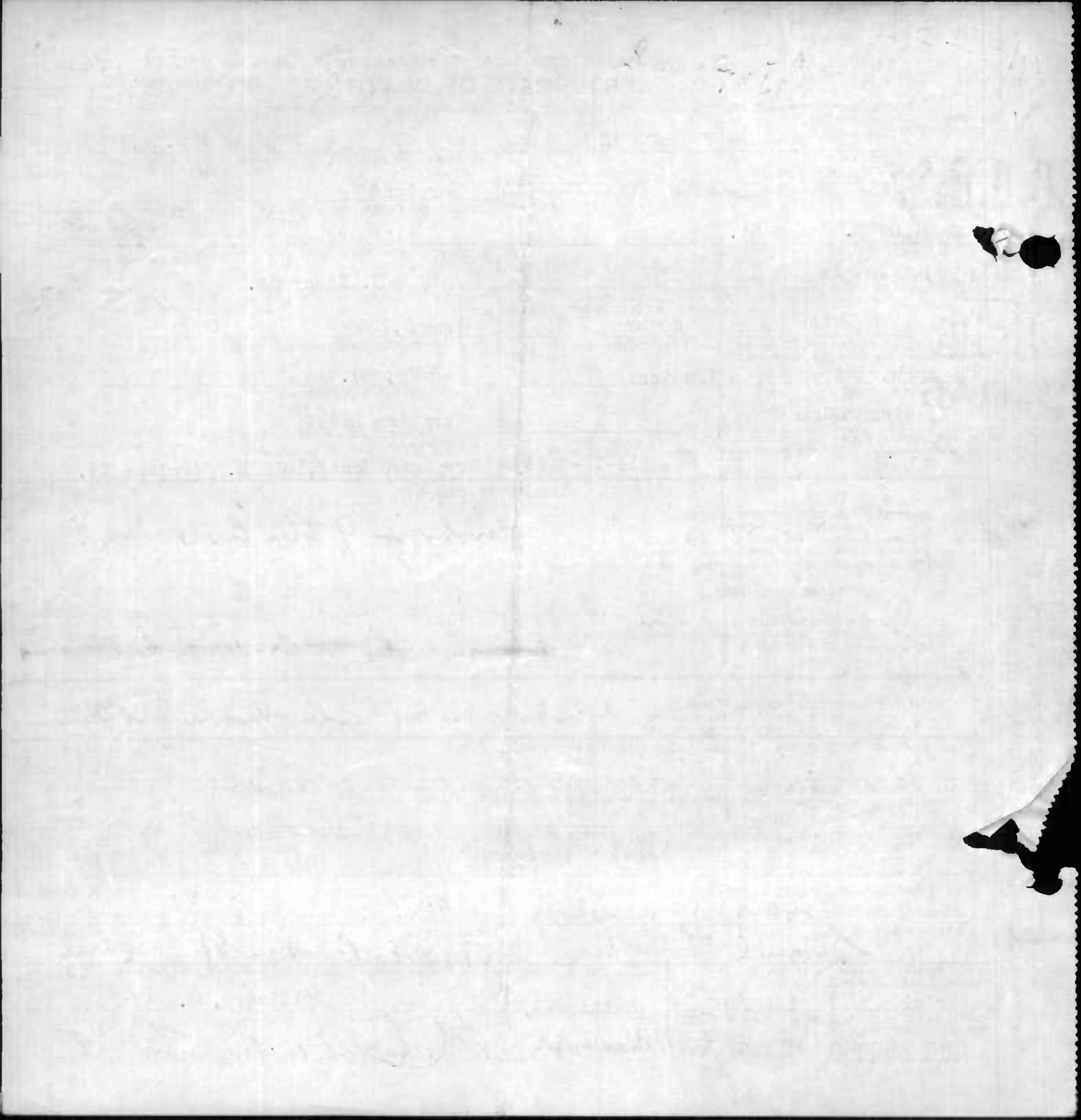
| | | |
|--|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS 1219 St Paul St |
|--|---|--|

VS 150

124.2

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.



R-563
50 7401BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7401

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary (Marie) Anna Rehmert

2. DATE
OF
DEATH

August 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

3430 Roland Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3430 Roland Avenue

c. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

May 24, 1880

9. AGE (in years
last birthday)

70

11 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Beatin

14. MOTHER'S MAIDEN NAME

Margaret Fraitis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Marie M. Rouch 3430 Roland Avenue

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Myocardial
infarction
DUE TO(B) astherosclerosis
DUE TO(C) Membranous
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

2 years

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1-50, to 8/26/50, that I last saw the
deceased alive on 8/26/50, and that death occurred at 4:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county) (State)

Baltimore Co., Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 28 1950

Wm. H. Williams, M.D.

Burgee Funeral Home

3631 Falls Road

VS 150

093.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. James H. Daffell
Purdue University 232

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7402

Registered No. _____

BIRTH NO. 426

| | | | | | |
|---|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) HILKER, DANIEL DAVID | | | 2. DATE OF DEATH 8-25-1950 OF 8:05 A.M. | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY Baltimore | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. | | |
| c. Length of stay in Baltimore 60 years | | | D. STREET ADDRESS (If rural, give location) 1213 W. 41st St. 13-08 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 3-24-1880 | | 9. AGE (In years last birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY Lodges Prince Neck Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Daniel Baker Hilker | | 14. MOTHER'S MAIDEN NAME Elizabeth Anne Burkner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 2-16-07-2542 | | 17. INFORMANT H. D. Hilker | |

| | | | |
|--|--|--|----------------------------------|
| 18. 157X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH Ca. of the head of pancreas (A) _____ DUE TO Obstruction of the common bile duct (B) _____ DUE TO Shock. (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|----------------------------------|

| | | | | | |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 8-14-50 , 19 50 , to 8-25-50 , 19 50 , that I last saw the deceased alive on 8-25 , 19 50 , and that death occurred at 8:05 m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Thurston Williams | | 23B. ADDRESS Franklin Square Hosp. | | 23C. DATE SIGNED 8-25-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 28-1950 | | 24C. NAME OF CEMETERY OR CREMATORY St. Mary's (Catholic) | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25. FUNERAL DIRECTOR Thurston Williams | | ADDRESS 3631 Falls Road. | |

58347

046.7

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1. Name of the plant: *...*

2. Locality: *...*

3. Date of collection: *...*

4. Collector: *...*

5. Description of the plant: *...*

6. Uses: *...*

7. Remarks: *...*

8. Distribution: *...*

9. Cultivation: *...*

10. Other: *...*

H 616 50 7403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7403

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mildred Katherine Bond Harper

2. DATE
OF
DEATH August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

3642 Beech Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3642 Beech Avenue

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov. 28, 1895

9. AGE (In years
last birthday)

54

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Inspector Cloth Room

10B. KIND OF BUSINESS OR
INDUSTRY

Mt. Vern. Woodberry Mills Maryland

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Charles E. Harper

Retired 2 years

14. MOTHER'S MAIDEN NAME

Emma J. Mathews

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
215-07-6400

17. INFORMANT

ADDRESS

Mrs. Mildred Weitzell 3642 Beech Avenue

18.

592X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

11 yrs

11 yrs.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5:00 p.m., 1950 to 2:50 a.m., 1950 that I last saw the
deceased alive on 25 Aug., 1950, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Aug. 28, 1950

Mt. Zion

Freelands, Baltimore Co., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 28 1950

Huntington Williams, M.D.

Burgee Funeral Home 3631 Falls Road

VS 150

6904E

1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

Mr. Henry D. Connolly
136. Cooper St.
Que 7447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FRIEDMAN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7404

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

(MARKOFF)

ANNA E FRIEDMAN

2. DATE
OF
DEATH

8/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

SINAI HOSP.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

#17 Balto. Md. 13-04

D. STREET ADDRESS (If rural, give location)

2921 Parkwood Ave

C. Length of stay in Baltimore

42 yrs.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

1877

9. AGE (In years last birthday)

72

10 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Boris Pincus

14. MOTHER'S MAIDEN NAME

Debora Fine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

David Markoff- 3204 Dorchester Road

18.

331X1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebro-Vascular Accident

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug, 1950, to Aug 26, 1950, that I last saw the deceased alive on Aug 26, 1950, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert Sander

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-28-50

24C. NAME OF CEMETERY OR CREMATORY

Shaarei Tfiloh Cong.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR

ADDRESS

AUG 28 1950

Huntington Williams, M.D.

Sol. Levinson & Bros W. North Ave.

1900

1900

1900

1900

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1900

1900

1900

1900

1900

1900

1900

1900

1900

PLEASE WRITE IN INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7405
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

YETTA SALZMAN

2. DATE
OF
DEATH

8-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

LEVINDALE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO.

27-17

C. Length of stay in Baltimore

40

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

GREEN SPRING AVE

LEVINDALE

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

65

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

U.S.-9

13. FATHER'S NAME

NOT KNOWN

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

N. E. KIMMEL - 1736 W. NORTH AVE

18.

151X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cancer of stomach

INTERVAL BETWEEN ONSET AND DEATH

18 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8-16, 1950, to 8-26, 1950, that I last saw the deceased alive on 8-26, 1950, and that death occurred at 11 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry Nagel

23B. ADDRESS

Levin Dale Home

23C. DATE SIGNED

8-26-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/28/1950

24C. NAME OF CEMETERY OR CREMATORY

ROSEDALE

24D. LOCATION (City, town, or county)

BALTO

MD

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

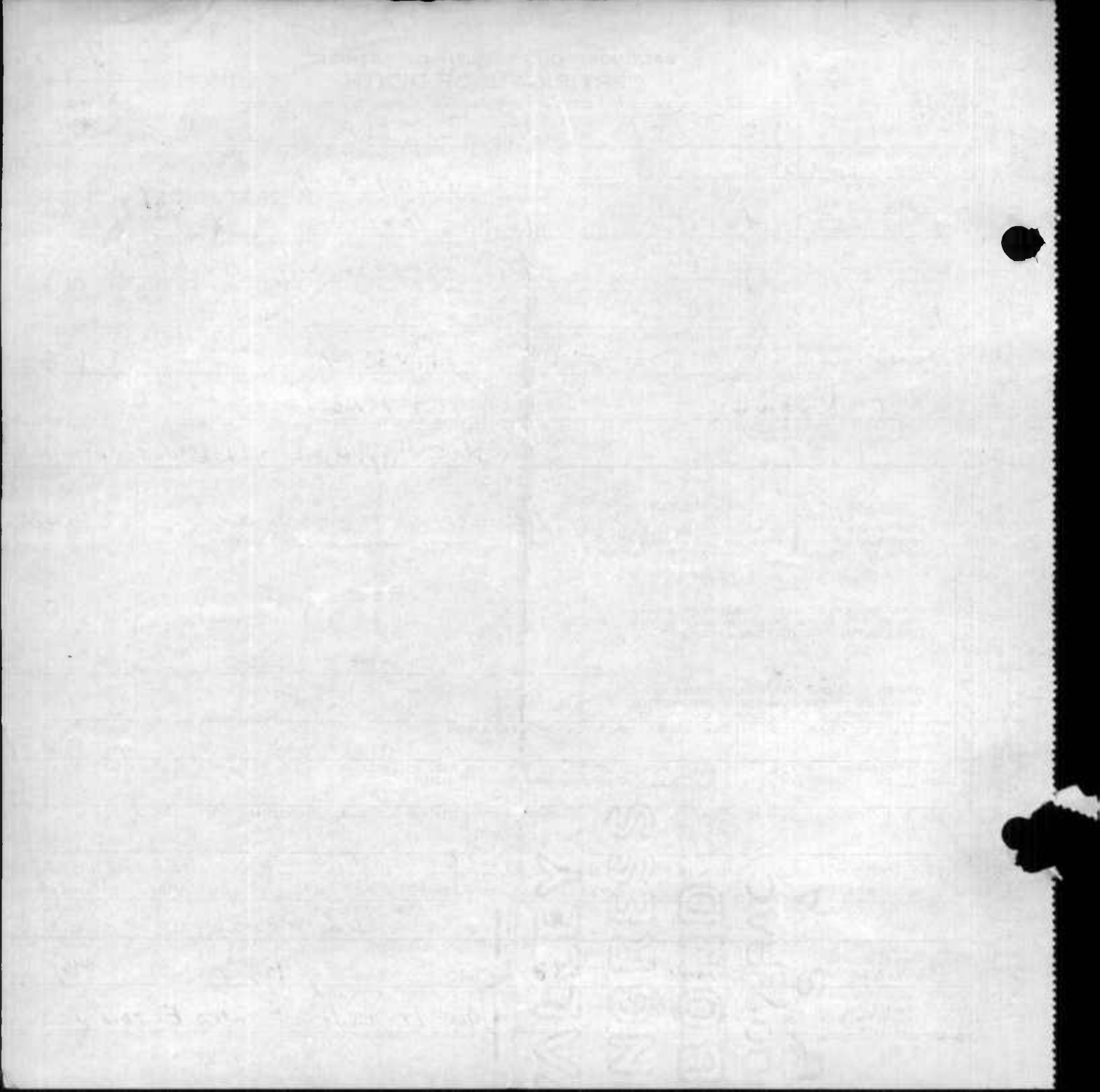
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

WALKER LEWIS INC - 2100 EUREKA PL



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7406BIRTH NO. 50 7406

| | | | | | |
|--|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>John Kruger</u> | | | 2. DATE OF DEATH <u>Aug 26, 1950</u> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto., Md.</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>408 N. Hilton St</u> | | | C. CITY OR TOWN (If outside corporate limits, write name L and give township) <u>Baltimore</u> <u>20-07</u> | | |
| c. Length of stay in Baltimore <u>life</u> | | | D. STREET ADDRESS (If rural, give location) <u>408 N. Hilton St.</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u> | 8. DATE OF BIRTH <u>Apr. 18, 1874</u> | | 9. AGE (In years last birthday) <u>76</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist & engineer - power plant</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Ferdinand Kruger</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Miller</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>215-03-3472</u> | 17. INFORMANT ADDRESS <u>Miss Frieda Kruger 408 N. Hilton St</u> | | |

MEDICAL CERTIFICATION

| | | |
|---|--|---|
| 18. <u>162X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Bromogenic Carcinoma.</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>? 3 to 4 mos</u> |
| ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <u>arterio sclerotic cardio-vascular disease.</u> | | <u>7</u> |

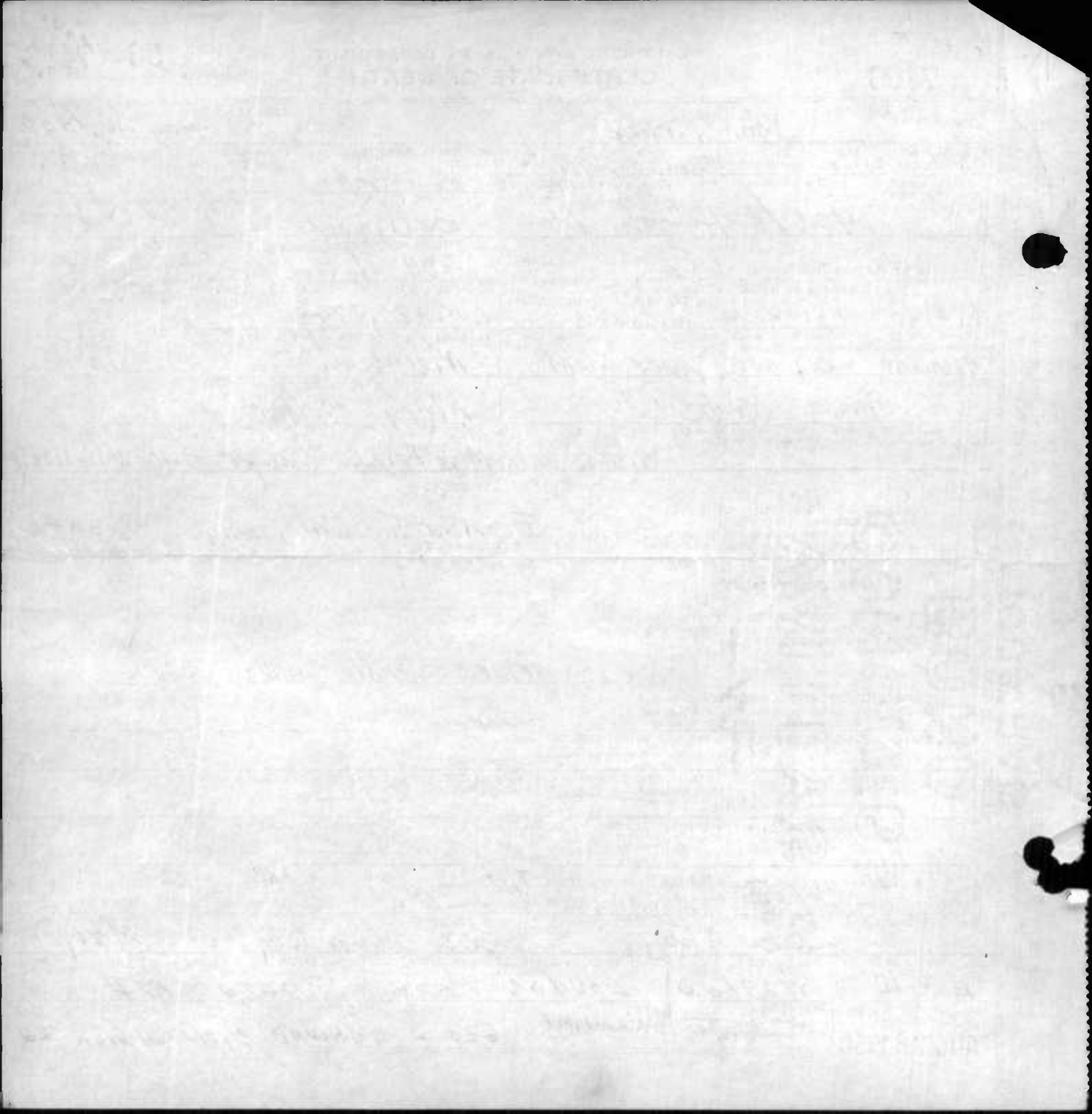
| | | | | | |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION <u>8/26/50</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>7/14</u> ¹⁹⁵⁰ , to <u>8/26</u> ¹⁹⁵⁰ , that I last saw the deceased alive on <u>8/26</u> ¹⁹⁵⁰ and that death occurred at <u>6⁰⁰ A. M.</u> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>Seam Krupp</u> | | 23B. ADDRESS <u>3030 Edmondson Ave.</u> | | 23C. DATE SIGNED <u>8/26/50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>8/29/50</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u> | | 25. FUNERAL DIRECTOR ADDRESS <u>Gco. L. SCHWAB 2101 Frederick Rd</u> | | | |

AUG 28 1950

VS 150

047.3

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.



N-450
50 7407BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7407
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERNARD J. NOLAN

2. DATE
OF
DEATH

AUG 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MD.

BALTO. CITY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

UNIVERSITY HOSP.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTIMORE 12-02

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3501 N. CALVERT

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Dec. 18, 1866

9. AGE (In years
last birthday)

83

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

retired (credit)

10B. KIND OF BUSINESS OR
INDUSTRY

Shirts

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

PATRICK Nolan

14. MOTHER'S MAIDEN NAME

MARY MC HUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS

18.

181X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) CARCINOMA OF BLADDER

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7-17-50 3

19B. MAJOR FINDINGS OF OPERATION

C.A. OF URINARY BLADDER

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1950, to Aug 26, 1950, that I last saw the
deceased alive on Aug 25, 1950, and that death occurred at 1:05 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Virginia Hubbs

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, Jr.

25. FUNERAL DIRECTOR

Wm. J. Pickens & Sons Balto.

ADDRESS

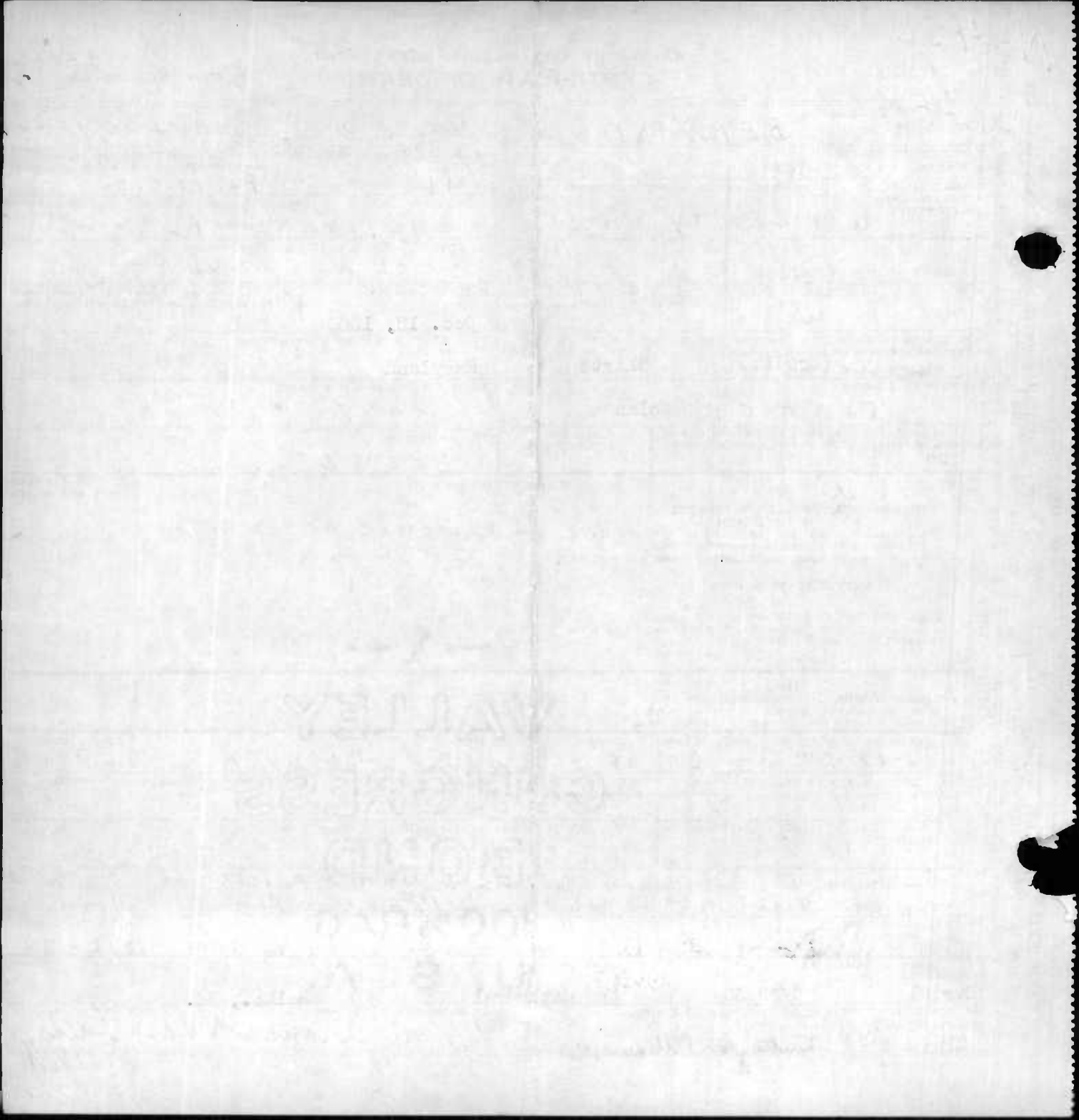
Md.

052.2

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7408
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JESSAMINE MARTIN RYLEY

2. DATE
OF
DEATH

Aug. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3405 Fairview Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3405 Fairview Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Nov. 1, 1876

9. AGE (In years last birthday)

73

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

David B. Martin

14. MOTHER'S MAIDEN NAME

Caroline W. Nauwerth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Clarence D. Foster 5502 Groveland Ave.

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease 6 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis ?

DUE TO

(C) Nephrosclerosis 1 yr.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1949, to Aug. 25, 1950, that I last saw the deceased alive on 8-25-1950 and that death occurred at 9 P m., from the causes and on the date stated above.

23A. SIGNATURE

Robert M. Heine M. D.

23B. ADDRESS

3105 N. Charles St.

23C. DATE SIGNED

8-26-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/28/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Chas. J. Fickner & Sons - Balto Md.

AUG 28 1950
VS 150

131.1

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. The first part of the paper is devoted to a general discussion of the subject.

2. The second part of the paper is devoted to a detailed discussion of the subject.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 7409**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JUNE ELIZABETH UTTS

2. DATE
OF
DEATH

Aug. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1501 Eutaw Place

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1501 Eutaw Place

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

June 29, 1871

9. AGE (In years last birthday)

79

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Iowa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Hannah R. Brown

14. MOTHER'S MAIDEN NAME

Rachael E. Fischel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

none

17. INFORMANT ADDRESS

Mr. Jay Utts - 812 St. Paul St.

18.

153X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma of colon**

6 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral arteriosclerosis

10 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 25, 1950** to **Aug 25, 1950** that I last saw the deceased alive on **Aug 25, 1950** and that death occurred at **1:15 P.M.** from the causes and on the date stated above.

23A. SIGNATURE

Herbert H. Gundershimer, M.D.

23B. ADDRESS

Riverside Lake Drive

23C. DATE SIGNED

Aug. 26 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

8/30/50

24C. NAME OF CEMETERY OR CREMATORY

Arlington National Cem.

24D. LOCATION (City, town, or county)

Arlington, Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Pickens & Sons Balto Md.

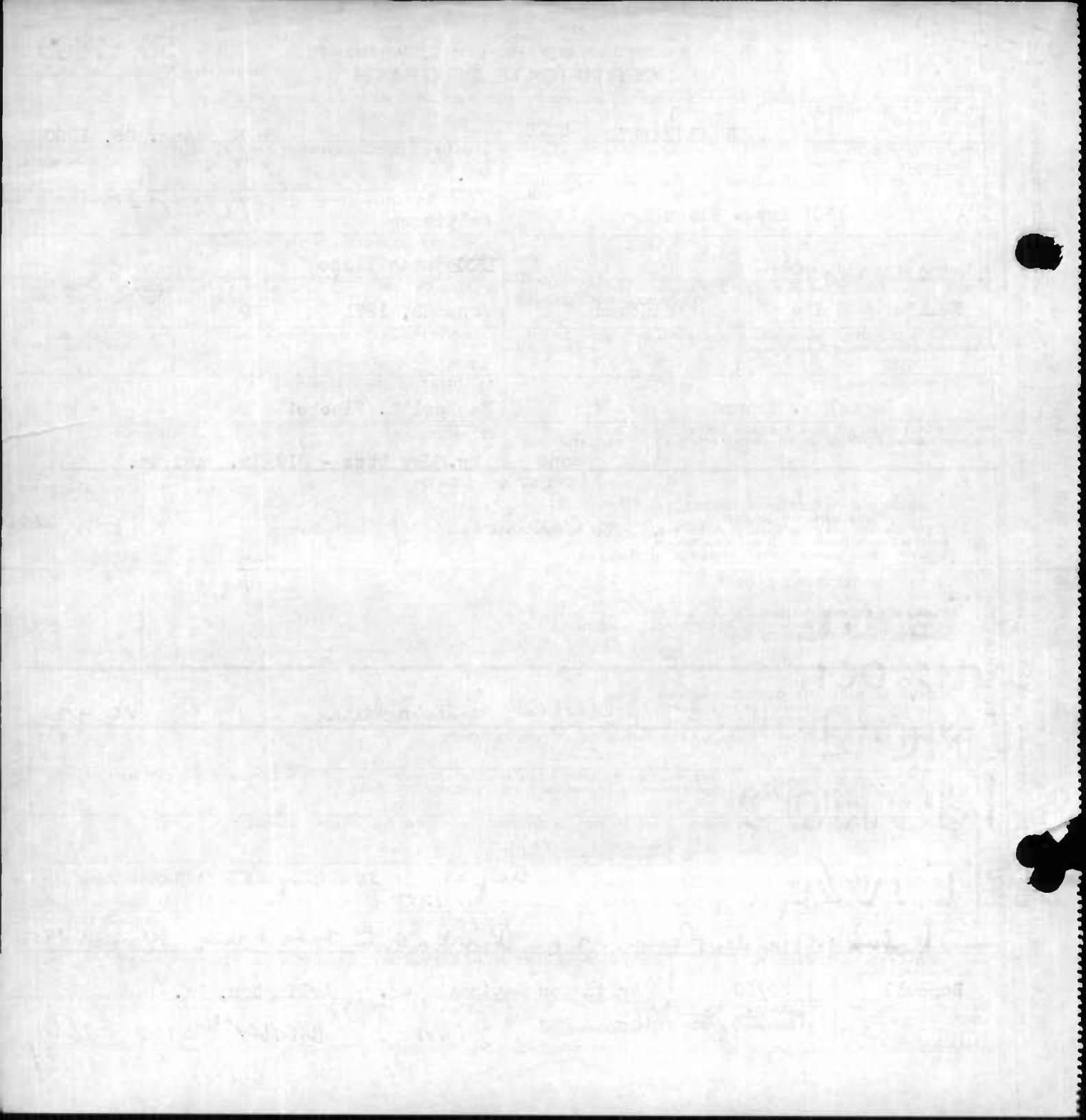
ADDRESS

VS 150

0465

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7410
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

D. Clifford Crook, Sr.

2. DATE
OF
DEATH Aug. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1600 Ellamont St.,

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1600 Ellamont St.,

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

12/12/1881

9. AGE (in years
last birthday)

68

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired Guard

10B. KIND OF BUSINESS OR
INDUSTRYUnited Fruit
Co.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Daniel Crook

14. MOTHER'S MAIDEN NAME

Carolyn Rollins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Helen Carey Crook 1600 Ellamont

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of right tonsil
and adjacent tissues
(treated at marine hospital)INTERVAL BETWEEN
ONSET AND DEATH

5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Sudden death - probably heart.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from cir., 1948, to 7, 1950, that I last saw the
deceased alive on Feb. 18, 1950, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Maurice E. Shaver, M.D.

23B. ADDRESS

3300 W. North Ave

23C. DATE SIGNED
August 26/5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8-29-1950

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park

24D. LOCATION (City, town, or county)

Woodlawn,

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

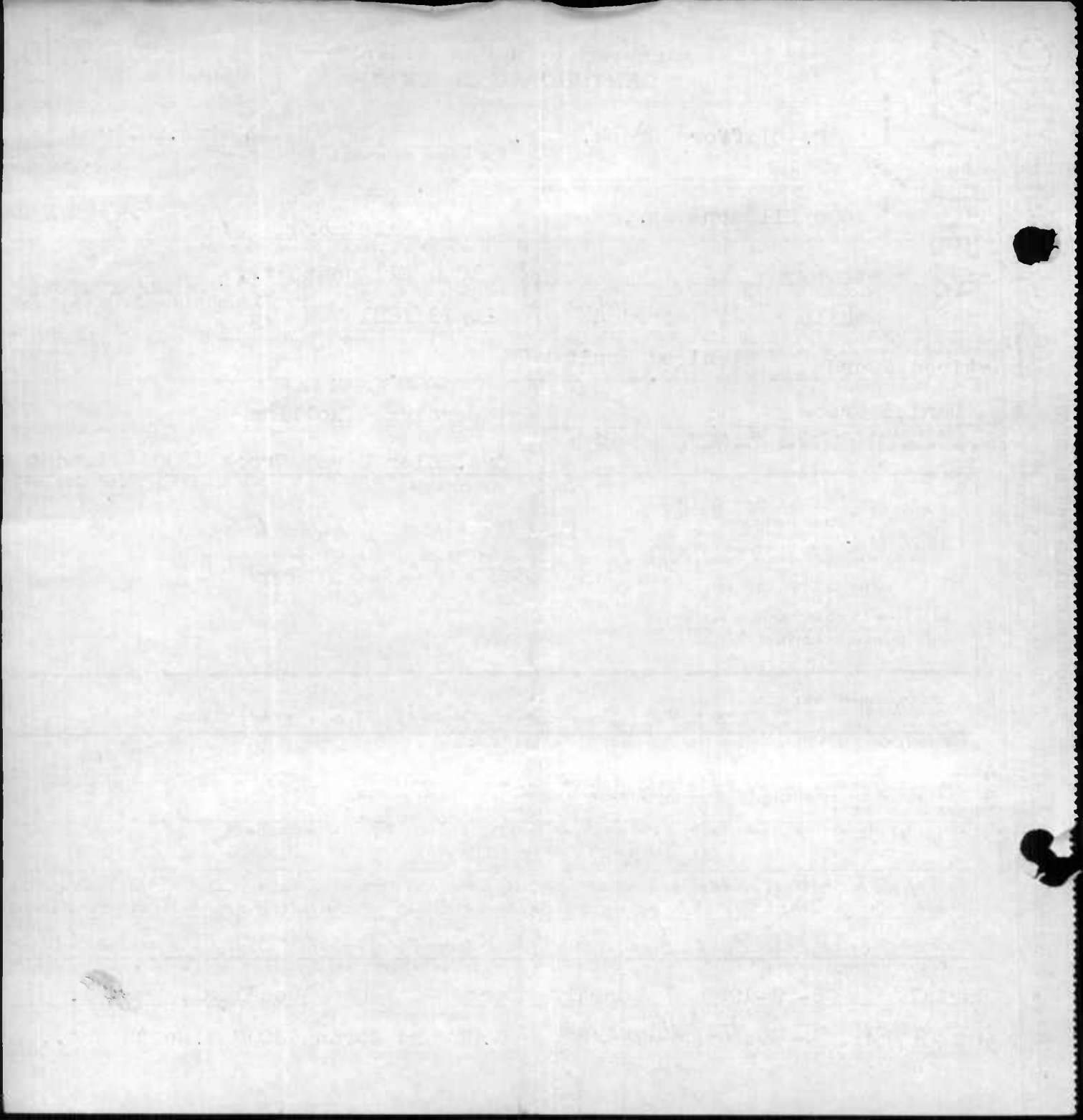
REGISTRAR'S SIGNATURE

L. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7411

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES BROWN

2. DATE
OF
DEATH

AUG 21 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, 3-02

D. STREET ADDRESS (If rural, give location)

1009 GRANBY ST.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

*6-15-50

9. AGE (in years
last birthday)10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Brown

14. MOTHER'S MAIDEN NAME

Helen Berkley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

delirium in acidosis -
peripheral circulatory
collapse

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

anemia, etiol. unknown

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to 8-21-, 1950 that I last saw the
deceased alive on 8-21-, 1950 and that death occurred at 1 A m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Elton Crystowsky

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8/24/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 28 1950

Lutington Williams, M.D.

VS 150

(* see over)

119.1

Got date of birth
by calling Barnett Lane.
They did not know history,
so could not obtain
place of birth. From
what I could, overheard,
over phone, —
it might be under
another name.

E. Stern
8.29.50

8/29/50

Mr. Peter P. P. P.

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

50 7412

BIRTH NO. 50-16483

1. NAME OF DECEASED
(Type or Print)

Baby of Pauline Aquilla

2. DATE
OF
DEATH

August 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1037 Rutland Avenue

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

August 6, 1950

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lawrence Towns

14. MOTHER'S MAIDEN NAME

Pauline Aquilla

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Records

18.

768.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Septicemia

INTERVAL BETWEEN
ONSET AND DEATH

unknown

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Prematurity

11 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from August 6, 1950, to August 17, 1950, that I last saw the
deceased alive on August 17, 1950, and that death occurred at 2:35 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

601 North Broadway

8-18-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

STATE OF TEXAS
COUNTY OF DALLAS

THIS CERTIFICATE OF DEATH is hereby given to the public, that the following person has died:

| NAME | AGE | SEX | RACE | DATE OF BIRTH | DATE OF DEATH | PLACE OF BIRTH | PLACE OF DEATH | Cause of Death | Signature of Physician | Signature of Coroner |
|----------|-----|-----|------|---------------|---------------|----------------|----------------|----------------|------------------------|----------------------|
| JOHN DOE | 45 | M | W | 1910-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JANE DOE | 35 | F | W | 1920-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JOHN DOE | 45 | M | W | 1910-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JANE DOE | 35 | F | W | 1920-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JOHN DOE | 45 | M | W | 1910-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JANE DOE | 35 | F | W | 1920-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JOHN DOE | 45 | M | W | 1910-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JANE DOE | 35 | F | W | 1920-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JOHN DOE | 45 | M | W | 1910-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |
| JANE DOE | 35 | F | W | 1920-01-01 | 1955-01-01 | NEW YORK, N.Y. | DALLAS, TEXAS | HEART DISEASE | [Signature] | [Signature] |

R-563
50 7413-18

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 7413

| | | | | | |
|---|----------------------------------|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JANET L. REINHARDT | | | 2. DATE OF DEATH Aug 26, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland HLH 4E | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE District of Columbia B. COUNTY Washington | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Washington | | |
| c. Length of stay in Baltimore Yrs. — Mos. — Days — | | | D. STREET ADDRESS (If rural, give location) 3504 CLAY ST. V-48 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) — | 8. DATE OF BIRTH 8-3-50 | | 9. AGE (in years last birthday) 23 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) D. C. | |
| 13. FATHER'S NAME MIKE T. REINHARDT | | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT JOHNS HOPKINS HOSPITAL |
| | | | | | ADDRESS |

| | | |
|--|---|--|
| 18. 754.6 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 954X | CAUSE OF DEATH Cardiac Arrest during operation for Congenital Heart Disease | INTERVAL BETWEEN ONSET AND DEATH — |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (A) DUE TO (B) DUE TO (C) DUE TO | |

| | | | | | |
|--|--|---|--|--|--|
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CERTIFICATION APPROVED BY Henry A. Dubach Per. O. J. Lubinski, M.D. CHIEF OR ASST. MEDICAL EXAMINER <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 19A. DATE OF OPERATION 26 Aug, 1950 | | 19B. MAJOR FINDINGS OF OPERATION Pulmonic Stenosis | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Johns Hopkins Hospital | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 26, 1950 7:35 P.m. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Ingestion of ether anesthesia | |
| 22. I hereby certify that I attended the deceased from 8-15 , 19 50 , to 8-26 , 19 50 , that I last saw the deceased alive on 8-26 , 19 50 , and that death occurred at 7:40 P.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE JNP Johns | | M. D. JOHNS HOPKINS HOSPITAL | | 23B. ADDRESS 3504 CLAY ST. V-48 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 8/28/50 | | 24C. NAME OF CEMETERY OR CREMATORY Forest Lawn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Richmond, Va. | | 24E. FUNERAL DIRECTOR Schimmunek Funeral Home, Inc. | | 24F. ADDRESS 2601 1/2 E. Madison St. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | | |

VS 150

Medical & Case to be approved 157.5

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Cardiac Arrest during
operation for
Coronary Heart
Disease

26 Aug 1950

Palmer's Standard

Mr. J. H. Palmer

Director of the

R-163
50 7414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) **Alice Roberts** 2. DATE OF DEATH **8-28-50**

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE **2209 Belair Rd** B. COUNTY **8-01**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **2209 Belair Rd.** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore 13, Md**

D. STREET ADDRESS (If rural, give location) **2209 Belair Rd.** c. Length of stay in Baltimore **Three** Yrs. **Mon.** **Days**

5. SEX **Female** 6. COLOR OR RACE **White** 7. ~~SINGLE~~ ~~MARRIED~~ **WIDOWED** 8. DATE OF BIRTH **9-28-80** 9. AGE (In years last birthday) **69** If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Home** 10B. KIND OF BUSINESS OR INDUSTRY **-** 11. BIRTHPLACE (State or foreign country) **Tyaskin, Md** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **James Horner** 14. MOTHER'S MAIDEN NAME **Jane Hurley**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **-** 17. INFORMANT ADDRESS **Iris White - 2209 Belair Rd.**

18. **422.1** I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

(A) **Arteriosclerotic cardiovascular disease** DUE TO **lar disease** ?

ANTECEDENT CAUSES (B) **Generalised arteriosclerosis** DUE TO **Sis**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) _____

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK m. 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-12-**, 19**50** to **8-26-**, 19**50**, that I last saw the deceased alive on **8-26-**, 19**50**, and that death occurred at **1 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE **Sueton C. Carey** M. D. 23B. ADDRESS **2117 Belair Rd** 23C. DATE SIGNED **8-28-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **9/30/50** 24B. DATE **9/30/50** 24C. NAME OF CEMETERY OR CREMATORY **Mt Vernon** 24D. LOCATION (City, town, or county) (State) **Princess Anne, RFD #1**

DATE RECEIVED BY LOCAL REGISTRAR **AUG 28 1950** REGISTRAR'S SIGNATURE **Wilmington Williams, Md** 25. FUNERAL DIRECTOR ADDRESS **Dale H. Haskell 093.4 Princess Anne, Md**

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF TEXAS
COUNTY OF DALLAS

WITNESSES
J. J. [illegible]
J. J. [illegible]

Subscribed and sworn to before me this [illegible] day of [illegible] 19[illegible]

Notary Public in and for the State of Texas

My Comm. Expires [illegible]

Notary Public in and for the State of Texas

Y
E
E

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John M Phillips

2. DATE
OF
DEATH

8/27/50

3. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

UNION MEMORIAL HOSP

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
Md.C. CITY OR TOWN (If outside corporate limits, write MORAL, and give township)
Baltimore 27-15

D. STREET ADDRESS (If rural, give location)

6000 Falls Road

C. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

April 8, 1874

9. AGE (In years
last birthday)

76

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Bldg. Custodian

10B. KIND OF BUSINESS OR
INDUSTRY

Police Bldg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frank Phillips

14. MOTHER'S MAIDEN NAME

Apelonia Williamson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Albert T. Phillips - 608 Venable Ave.

18.

E 900.01

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) FRACTURED SKULL
DUE TO with contusion of
brain

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Aug. 26, 1950 8:00 P.M.

21E. INJURY OCCURRED
WHILE AT ☐ WORK NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

RS Fisher

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

8/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tichenor & Sons Balto., Md.

VS 151

N-803.0

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORD OF DEATHS

1910

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

T-656
50 7416BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7416
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Emiline Turner

2. DATE
OF
DEATH

Aug. 25 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland
Baltimore 15-02

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1800 N. Mount St.

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1800 N. Mount St.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 4, 1869

9. AGE (in years last birthday)

81

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Lacey Co. Va

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Pendleton

14. MOTHER'S MAIDEN NAME

Katie Bird

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, if of unknown)

No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Rachel Turner

ADDRESS 1800 N. Mount St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

DUE TO

(C)

Hypertensive Heart

1 year.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-24-1950 to 8-25-1950, that I last saw the deceased alive on 8-25-1950 and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

George C. Page

M. O.

23B. ADDRESS

1816 N. Mount St.

23C. DATE SIGNED

8-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Atlantic Funeral Home

ADDRESS

1631 Druid Hill Ave.

AUG 28 1950

093.4

[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mirrored and difficult to decipher.]

PLEASE WRITE CORRECTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7417
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Matilda Bailey

2. DATE OF DEATH

Aug. 25, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHN HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Ind

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 14-07

D. STREET ADDRESS (If rural, give location)

1512 Madison Ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

5/29/96

9. AGE (In years last birthday)

54

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George Stewart

14. MOTHER'S MAIDEN NAME

Annie Lane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHN HOPKINS HOSPITAL

ADDRESS

18. *470.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Acute pulmonary edema*

12 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Acute myocardial infarction*

DUE TO

(C) *Hypertensive-cardiomegaly*

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/24*, 19*50*, to *8/25*, 19*50*, that I last saw the deceased alive on *8/25*, 19*50*, and that death occurred at *8:15* p. m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas J. Walsh

M. D.

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

8-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

Aug. 26, 1950

St. Andrew

Baltimore, Md.

August 28 1950

William H. Williams

Holland Funeral Home
1651 Druid Hill Ave.

093.4

17. 2. 1900

17. 2. 1900

17. 2. 1900

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY F STEWART

2. DATE
OF
DEATH

8/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland
Baltimore 13-03

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

D.O.A. Md. General Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2535 Salem St.

C. Length of stay in Baltimore

47 yrs.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Oct. 22, 1891

9. AGE (In years last birthday)

58

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Private family

11. BIRTHPLACE (State or foreign country)

Rockville, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.B.

13. FATHER'S NAME

Thomas Neal

14. MOTHER'S MAIDEN NAME

Anne Bowley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

Joseph Stewart 2535 Salem St.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) SUBARACHNOID HEMORRAGE
DUE TO RUPTURE OF CONGENITAL ANEURYSM OF CIRCLE OF Willis
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

8/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Arbuthnot Mem. Ch. Baltimore Co. Md.

24D. LOCATION (City, town, or county)

Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Funeral Home 1601 Laurel Hill Ave

5/12/15

MARY E. ST. JOHN

RECEIVED BY THE
CENTRAL WHITE CLAY

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-340 7419

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7419

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Daniel Reed

2. DATE
OF
DEATH

August 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-03

D. STREET ADDRESS (If rural, give location)

1615 Smallwood St

c. Length of stay in Baltimore

32 yrs.

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

8-21-93

9. AGE (in years last birthday)

57

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Fertilizer plant

11. BIRTHPLACE (State or foreign country)

Westmoreland Co. Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thompson Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Congestive Failure

5 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardio-vascular disease

unknown

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8-23, 1950, to 8-25, 1950, that I last saw the deceased alive on 8-25, 1950, and that death occurred at 8:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Herbert G. Langford

M. O.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Plc.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

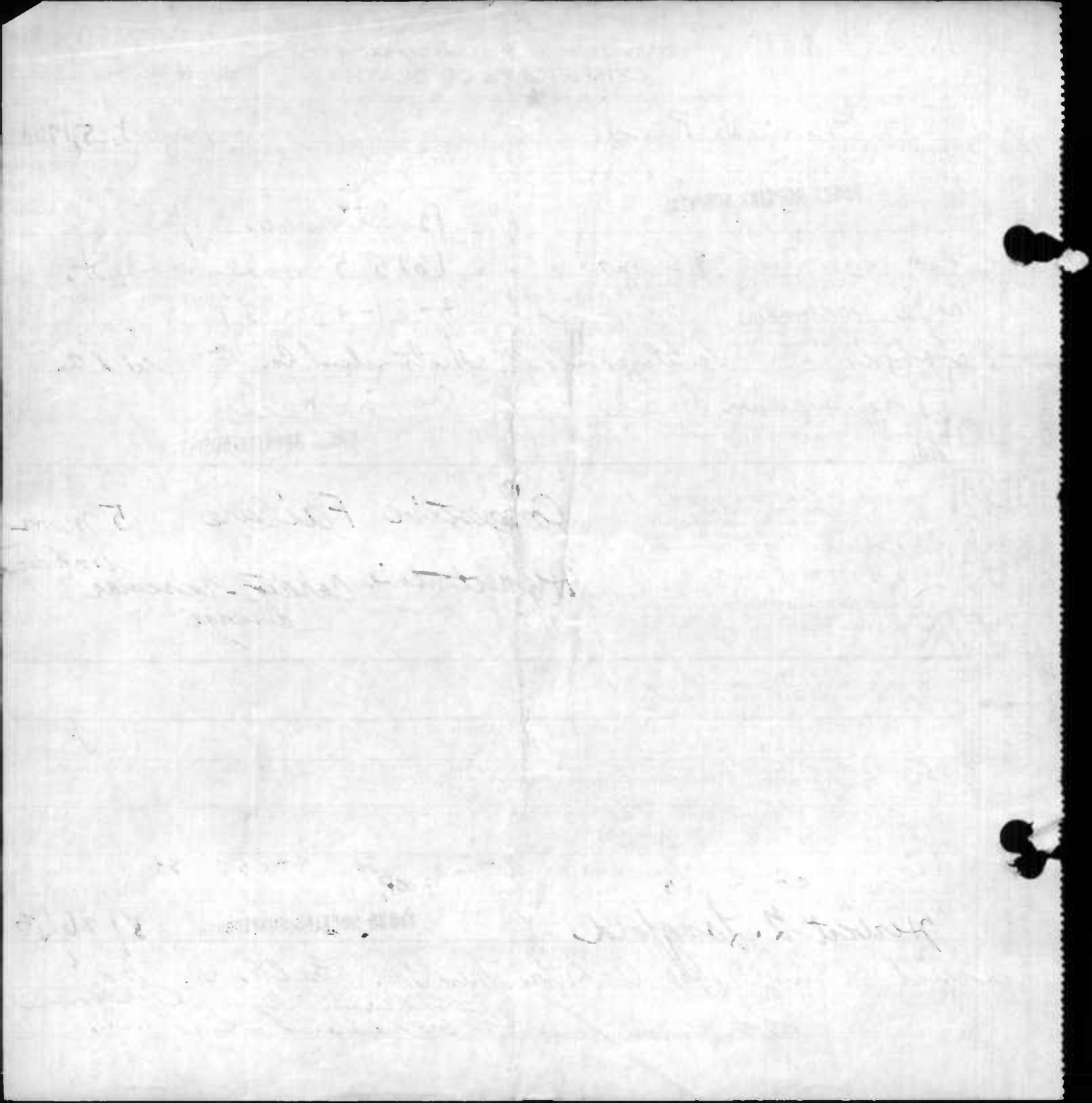
AUG 28 1950

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

Holland Funeral Home 1615 Smallwood Hill Cres



BALTIMORE CITY HEALTH DEPARTMENT

50 7420 Registered No. 50 7420

D-652

BIRTH NO. 50 7420

CERTIFICATE OF DEATH

CERTIFICATE CORRECTED 8-26-50

1. NAME OF DECEASED (Type or Print) **Elsie Deuringer**

2. DATE OF DEATH **8-26-50**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Baltimore** B. COUNTY **Md**

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

7. STREET ADDRESS (If rural, give location)
3729 Russell Ave.

8. Length of stay in Baltimore
Yrs. Mos. Days

9. SEX **F**

10. COLOR OR RACE **W**

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

12. DATE OF BIRTH **Sept. 10-1897**

13. AGE (In years last birthday) **51 58**

14. Under 1 Year Months Days

15. Under 24 Hours Hours Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

17. KIND OF BUSINESS OR INDUSTRY
Housewife

18. BIRTHPLACE (State or foreign country)
Baltimore Md.

19. CITIZEN OF WHAT COUNTRY?

20. FATHER'S NAME
William Latz

21. MOTHER'S MAIDEN NAME
Anna Reuckert

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

23. SOCIAL SECURITY NO.

24. INFORMANT
Mr. Frank J. Deuringer - 3729

25. CAUSE OF DEATH

26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive CVD

27. ANTECEDENT CAUSES
(B) S.I. disease

28. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Cong. failure

29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

30. DATE OF OPERATION

31. MAJOR FINDINGS OF OPERATION

32. AUTOPSY? YES ☐ NO ☐

33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

34. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

36. TIME (Month) (Day) (Year) (Hour) OF INJURY

37. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

38. HOW DID INJURY OCCUR?

39. I hereby certify that I attended the deceased from **Aug 1, 1950** to **Aug 26, 1950** that I last saw the deceased alive on **Aug 26, 1950**, and that death occurred at **7 PM**, from the causes and on the date stated above.

40. SIGNATURE **Elsie W. Deuringer** M. D.

41. ADDRESS **University Hosp**

42. DATE SIGNED **8-26-50**

43. BURIAL, CREMATION, REMOVAL (Specify)
Burial

44. DATE
8/30/50

45. NAME OF CEMETERY OR CREMATORY
Sacred Heart

46. LOCATION (City, town, or county) (State)
BalTo Md

47. DATE RECEIVED BY LOCAL REGISTRAR

48. REGISTRAR'S SIGNATURE
Thurston Williams

49. FUNERAL DIRECTOR
Leonard J. Luck

50. ADDRESS
5305 Bayford Rd

VS 150

AUG 28 1950

093.4

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F-640

50 7421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7421
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROSCOE DURAND FARLOW

2. DATE
OF
DEATH

8-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Yew.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

4710 KERNWOOD AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MD. 4710 Kernwood Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTO- 27-11

D. STREET ADDRESS (If rural, give location)

4710 KERNWOOD AVE

5. SEX

M.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
MARRIEDYrs.
Mos.
Days

8. DATE OF BIRTH

July 8, 1889

9. AGE (In years
last birthday)

61

10. Under 1 Year
Months: Days
11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR
INDUSTRY

automobile (R)

11. BIRTHPLACE (State or foreign country)

Pittsville MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S. citizen

13. FATHER'S NAME

Benj.

FARLOW.

14. MOTHER'S MAIDEN NAME

Louisiana Parsons FARLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

NO

16. SOCIAL
SECURITY NO.

212-12-2237

17. INFORMANT

Edith Patterson FARLOW Same

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Infarction of
myocardium

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Myocardium

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Infarction 1946, Hemorrhage - 5 yrs ago.
Arachnoid
Meningitis, mild nephritis - 1-2 yrsINTERVAL BETWEEN
ONSET AND DEATH

4-5 hrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

✓

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-27-1950, to 8/27-1950, that I last saw the
deceased alive on 5-27-1950, and that death occurred at 4 m., from the causes and on the date stated above.

23A. SIGNATURE

Victor Richards

23B. ADDRESS

3212 Quaker Rd

23C. DATE SIGNED

8/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

Aug. 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

PRESBYTERIAN CEM.

24D. LOCATION (City, town, or county)

CHURCHVILLE

MD.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

H.W. JENKINS & SONS Co. 4905 YORK RD.

ADDRESS

IT VALLEY
CONGRESS
RECORD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-200
50 7422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7422
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Rose Rice

2. DATE
OF
DEATH

8/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

4030 Belle Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Columbia Md 15-10

D. STREET ADDRESS (If rural, give location)

4030 Belle Ave

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct 19/1866

9. AGE (In years last birthday)

83

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Moscow Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Ackley

14. MOTHER'S MAIDEN NAME

McHugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Herbert L Rice 4030 Belle Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

arteriosclerotic C.V. disease

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

P. J. Lubinski

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☒

23C. DATE SIGNED

8/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

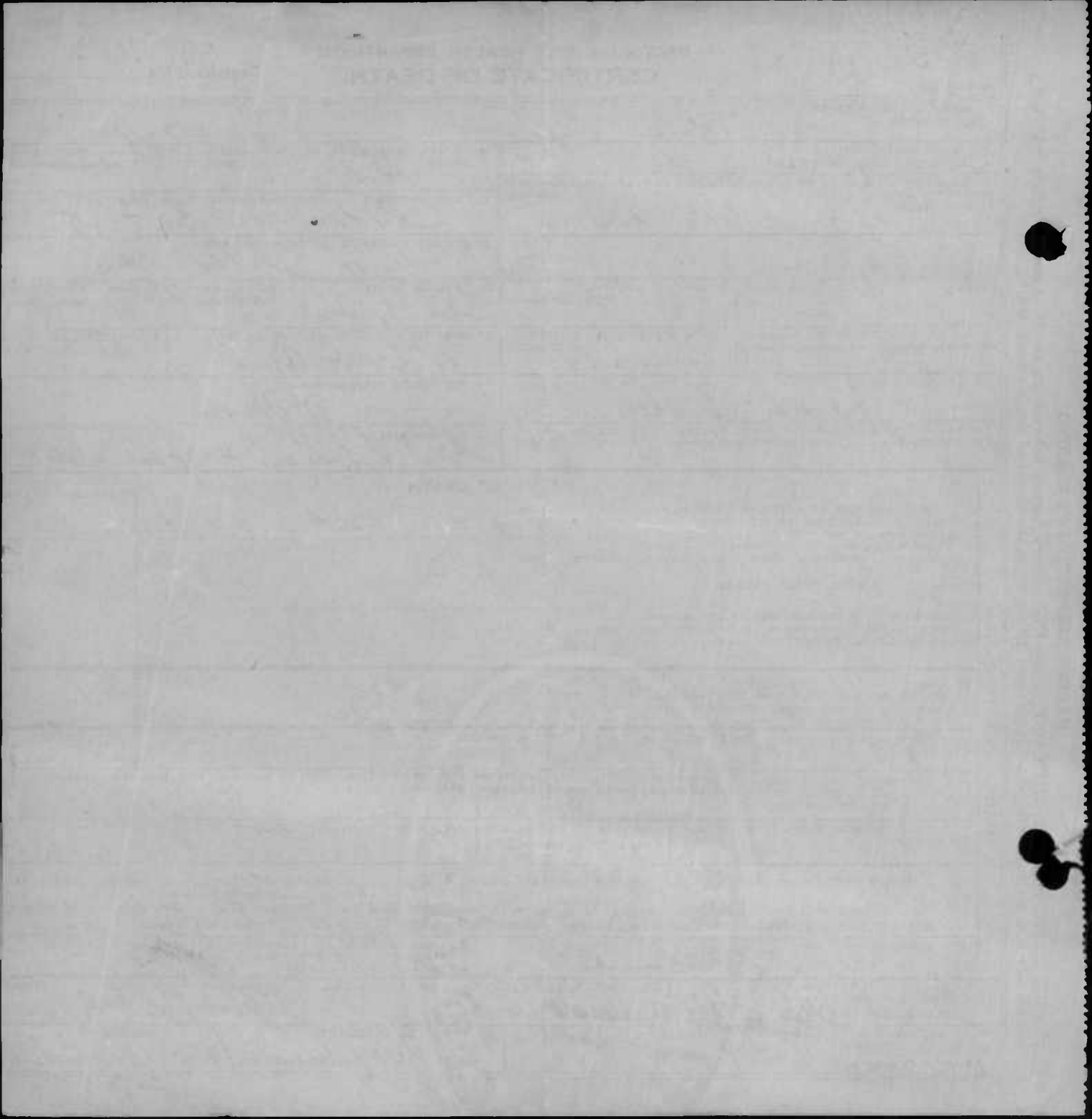
ADDRESS

Harry H. Munroe 204 Edgewood

AUG 28 1950

V S 151

093.4 V



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Lillian E. Dechsler

2. DATE
OF
DEATH

8/26/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived If institution: residence before admission)
A. STATE *Md.* B. COUNTY _____

B. FULL NAME OF _____
(If not in hospital or institution, give street address or location)

D.O.A. Balto. City Morgue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 26-85

D. STREET ADDRESS (If rural, give location)
523 S. Lippold St

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct-30-1902

9. AGE (In years last birthday)

47

10. Under 1 Year Months: Days

10

11. Under 24 Hours Hours: Min.

10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Peter J. Buttrum

14. MOTHER'S MAIDEN NAME

Conce Row

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Paul E. Dechsler

ADDRESS

18. *E975X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *DROWNING*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Creek

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Colegate Creek at Colegate Bridge

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
August 26, 1950

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Drowning, suicide

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED
8/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug-30-1950

24C. NAME OF CEMETERY OR CREMATORY

Mountland Park Co.

24D. LOCATION (City, town, or county)

Balto Co Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Kingston Williams

25. FUNERAL DIRECTOR

John B Connolly - 418 Eastern Ave

V S 151

N-990X

164 B V

MARGIN RESERVED

MEDICAL CERTIFICATION

PLEASE WRITE IN INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Paul C. Bickart
Gene Kow
6050-1905

Paul C. Bickart
Gene Kow
6050-1905

Paul C. Bickart
Gene Kow
6050-1905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7424

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERTHA BRENNER.

2. DATE
OF
DEATH

8/26/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE Md. B. COUNTY before admission)B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Church Home & Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 2-03

C. Length of stay in Baltimore

43 yrs.

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

519 S. Chapel Street.

5. SEX

F.

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married.

8. DATE OF BIRTH

8.26.1907.

9. AGE (In years,
last birthday)

44 yrs.

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife.

10B. KIND OF BUSINESS OR
INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baltimore.

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

John Petersen.

14. MOTHER'S MAIDEN NAME

Alvina Walters.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

445X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Uraemia.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Malignant hypertension.

DUE TO

(C)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/23/1950, to 8/26, 1950, that I last saw the
deceased alive on 8/25/1950, and that death occurred at 6:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Ruth Moore M.D.

M. D.

23B. ADDRESS

Church Home & Hospital 8/26/50

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

8-30-50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Livingston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler, Inc 403 S. Wolfe Street

CERTIFICATE OF DEATH

Baltimore, Md.

Dark Room

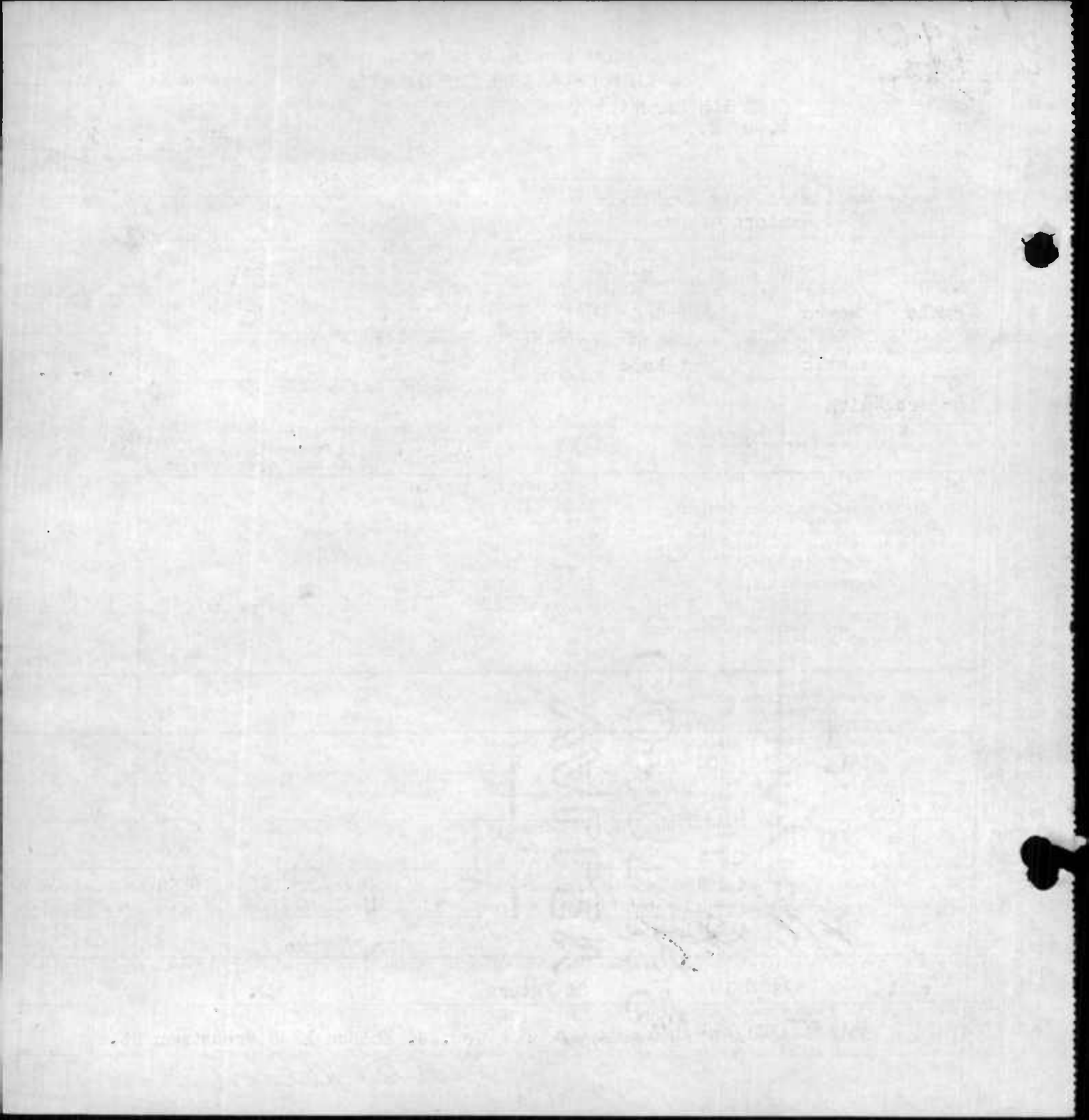
8-10-50

100 S. Wolfe Street, Baltimore, Md.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7425
Registered No. _____B-240
141095
50 7425
BIRTH NO. 7425

| | | | | | |
|--|---------------------------|--|--|---------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) (Smith Barnett) Irene R. Beasley | | | 2. DATE OF DEATH Aug. 25, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| c. Length of stay in Baltimore Life | | | D. STREET ADDRESS (If rural, give location) 529 Archer Street | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH ? ? ? | 9. AGE (in years last birthday) 48 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Robert Smith | | | 14. MOTHER'S MAIDEN NAME ? | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Baltimore City Hospitals Records* 4940 Eastern Avenue | | |

| | | | | | |
|--|--|---|--|--|---|
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage (A) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 3 Hrs. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive Cardiovascular Disease (B) DUE TO | | | Over 1 Yr. | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug. 25, 1950, to Aug. 25, 1950 that I last saw the deceased alive on Aug. 25, 1950, and that death occurred at 7:02 PM from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE H. Crozer | | 23B. ADDRESS 4940 Eastern Avenue | | 23C. DATE SIGNED 8-26-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/30/50 | | 24C. NAME OF CEMETERY OR CREMATORY St Peters | |
| 24D. LOCATION (City, town, or county) Md. | | 25. FUNERAL DIRECTOR Geo. G. Kelson 1303 Presstman St. | | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | | REGISTRAR'S SIGNATURE Thurston Williams, M.D. | | ADDRESS | |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Frank Freeman

2. DATE
OF
DEATH

8/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Mery Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1040 N. Stratton St.

c. Length of stay in Baltimore

27

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

Caucasian

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 4, 1904

9. AGE (In years
last birthday)

45

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

LONGSHOREMAN

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wesley Freeman

14. MOTHER'S MAIDEN NAME

Sarah Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Emma Freeman (wife)

ADDRESS

Same

18. 592X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Acute Pulmonary Edema

INTERVAL BETWEEN
ONSET AND DEATH

24 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Coronary Arteriosclerosis

24 hr.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Chronic Glomerulo-Nephritis - years?

Hypertensive C-V Disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/15/50, 19⁵⁰, to 8/25/50, 19⁵⁰, that I last saw the
deceased alive on 8/25, 19⁵⁰, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. S. S. S. S.

23B. ADDRESS

Mery Hospital

23C. DATE SIGNED

8/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Lane View

24D. LOCATION (City, town, or county)

Lane View, Va

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 28 1950

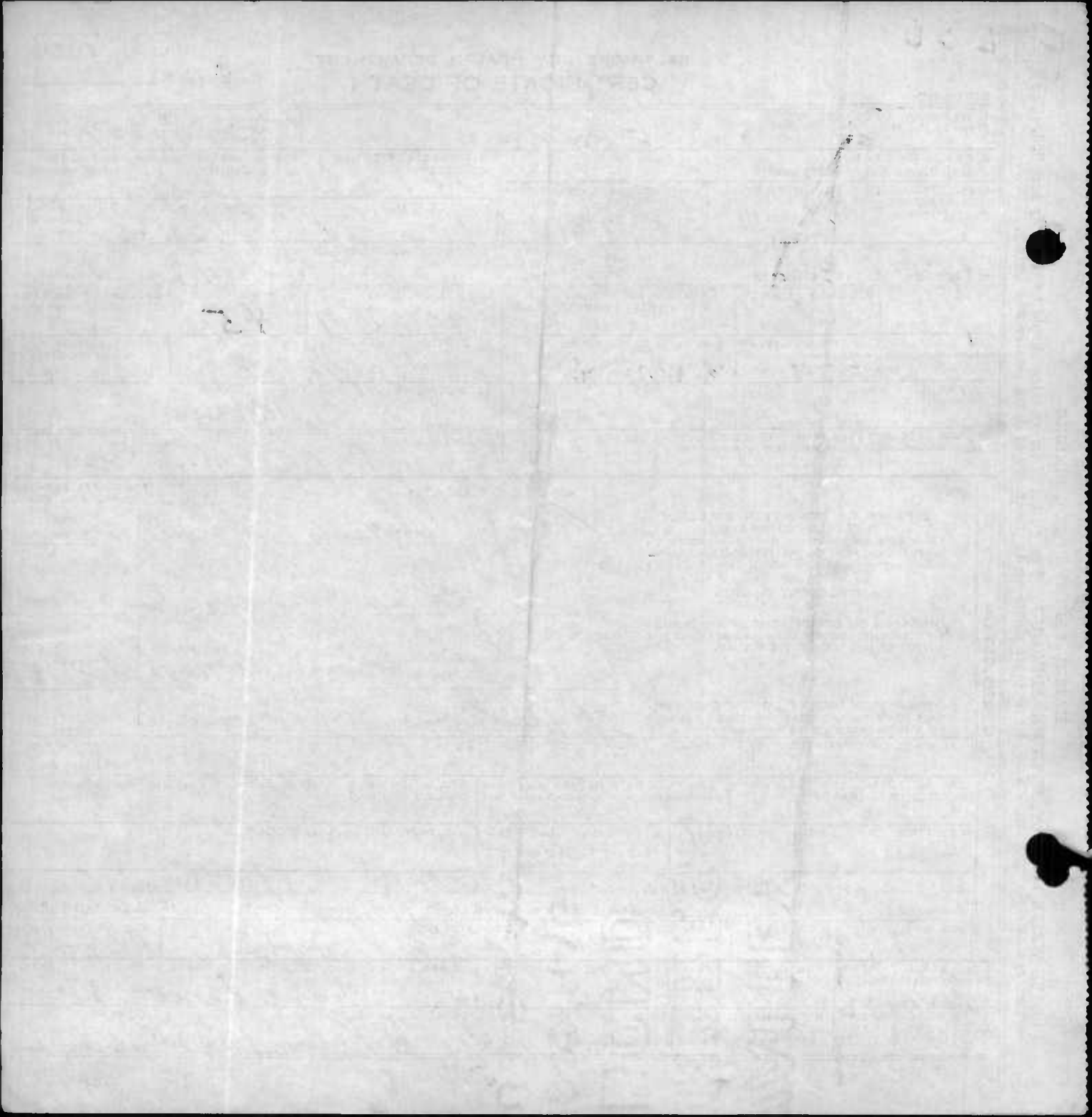
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Geo. S. Nelson / 1303 Chestnut

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7427
Registered No. _____

1. NAME OF DECEASED
(Type or Print)

Marie Lissau

2. DATE
OF
DEATH

August 26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Maryland General Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE *Maryland* B. COUNTY _____ before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION *Maryland General Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 20-07

c. Length of stay in Baltimore *Life*

D. STREET ADDRESS (If rural, give location)
3500 W Caton Avenue #29

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

April 1887

9. AGE (in years
last birthday)

63

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

house work

10B. KIND OF BUSINESS OR
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John KURTZ

14. MOTHER'S MAIDEN NAME

Elizabeth Binder

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT *MR RICHARD LISSAU - 1250 ARDRAVE AVE BALTO. 38*

18.

442X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) *Cardiac decompensation*

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) *Hypertensive Cardiovascular 10 yrs*
Renal disease with
encephalopathy

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *August 8, 1950* to *August 26, 1950*, that I last saw the
deceased alive on *August 26, 1950*, and that death occurred at *6:30* p. m., from the causes and on the date stated above.

23A. SIGNATURE

May M. Clift, M.D.

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

August 26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Memorial Pk. Dorsey, Md.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Wm. H. Williams, M.D.

25. FUNERAL DIRECTOR

Harry J. White 4401 Edmonson Ave

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2

[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7428
Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Michael Bottiger | | | 2. DATE OF DEATH August 27 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION 1955 W. FAYETTE ST | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-01 | | |
| c. Length of stay in Baltimore 69 Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 1955 W. FAYETTE ST | | |
| 5. SEX MALE | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH December 24 1880 | | 9. AGE (In years last birthday) 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST | | 10B. KIND OF BUSINESS OR INDUSTRY DRUG | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME George Bottiger | | | 14. MOTHER'S MAIDEN NAME BARBARA Bittner | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 216-09-1200 | | 17. INFORMANT ADDRESS MRS Bertha Bottiger SAME | |

18. **260X I** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diabetes Mellitus DUE TO

ANTECEDENT CAUSES
(B) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Right hemiplegia Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH
30 YRS
5 YRS
?

| | | | | | |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION June 1950 | | 19B. MAJOR FINDINGS OF OPERATION GANGRENE OF LEFT LEG | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from **July 28, 1950**, to **Aug 27, 1950**, that I last saw the deceased alive on **Aug 24, 1950**, and that death occurred at **8:30 P. M.**, from the causes and on the date stated above.

| | | |
|---|---|------------------------------------|
| 23A. SIGNATURE Melvin H. Borden | 23B. ADDRESS 2030 W. Fayette St | 23C. DATE SIGNED 8/27/50 |
|---|---|------------------------------------|

| | | | |
|--|--------------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 30/50 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park, 3801 Frederick Rd. | 24D. LOCATION (City, town, or county) (State) Baltimore 29, Md. |
|--|--------------------------------|--|---|

| | | | |
|--|--|---|--------------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | REGISTRAR'S SIGNATURE Winston Williams, M.D. | 25. FUNERAL DIRECTOR Harry H. White | ADDRESS 4101 Edmondson Ave |
|--|--|---|--------------------------------------|

STATE OF NEW YORK
CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

CITY

COUNTY

STATE

SIGNATURE OF REGISTRAR

DATE

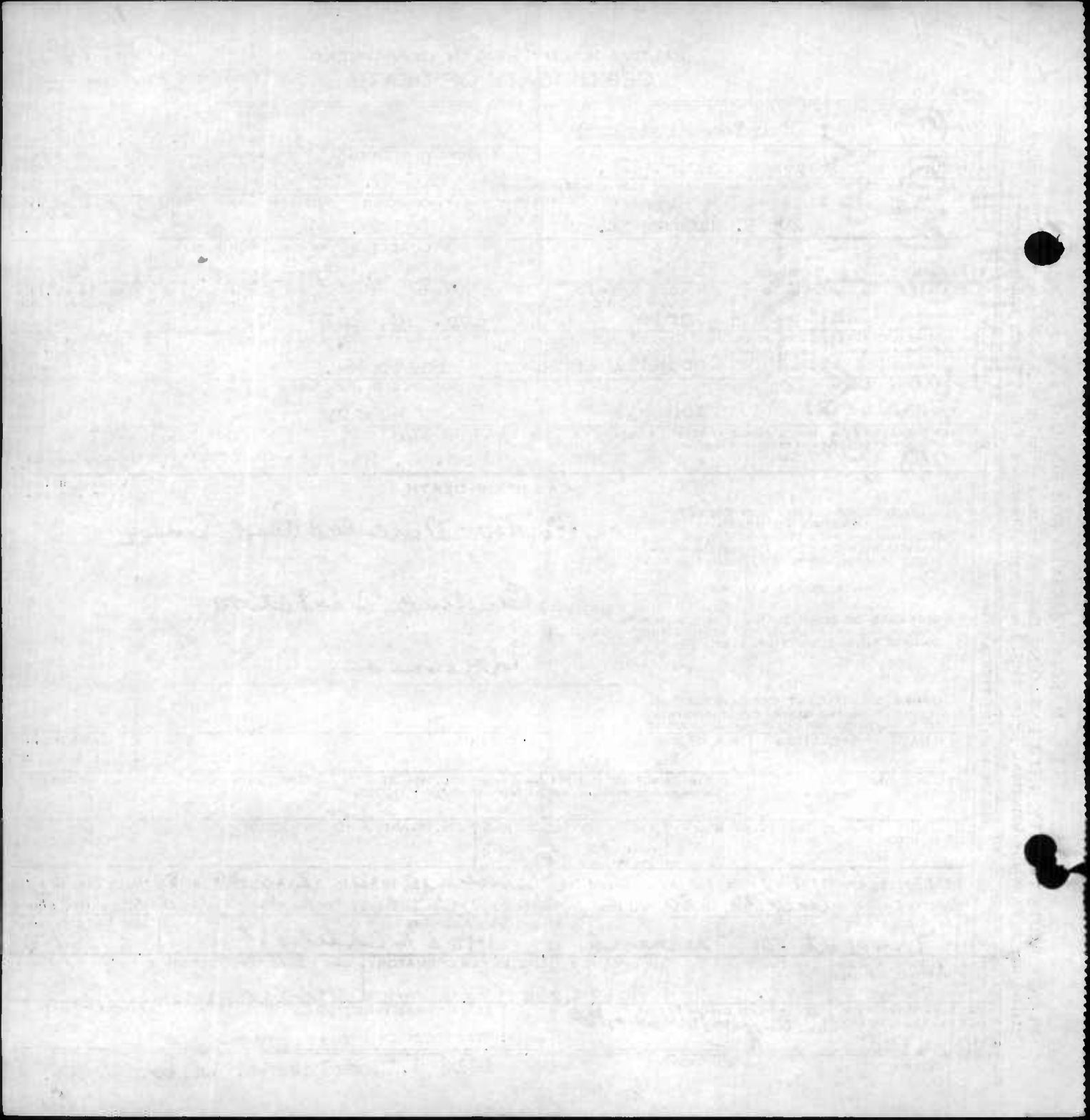
PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7429

Registered No.

| | | | | | |
|---|---------------------------|---|-----------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) John Charles Steinbach | | 2. DATE OF DEATH Aug. 26, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md. | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY 205 E. Hamburg St. | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 205 E. Hamburg St. | | C. CITY OR TOWN (If outside corporate limits, write (T) R(A) and give township) Balto. Md. | | | |
| c. Length of stay in Baltimore Life | | D. STREET ADDRESS (If rural, give location) 205 E. Hamburg St. Balto. 30 | | | |
| 5. SEX M | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Apr. 10, 1879 | 9. AGE (In years last birthday) 71 | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Finisher | | 10B. KIND OF BUSINESS OR INDUSTRY GoodWill Industry | | 11. BIRTHPLACE (State or foreign country) Balto Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Charles P. Steinbach | | 14. MOTHER'S MAIDEN NAME Mary McGary | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mrs. C. Steinbach 205 E. Hamburg St. | |
| 18. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardio-Vascular Renal Disease DUE TO ANTECEDENT CAUSES (B) Cardiac Dilatation DUE TO (C) Uremia OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from June 10, 1950 to Aug 26, 1950 that I last saw the deceased alive on Aug 26, 1950, and that death occurred at 3:45 A.M., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Vincent M. Messina M.D. | | 23B. ADDRESS 1403 S. Charles St | | 23C. DATE SIGNED 8/26/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 29/50 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | |
| 24D. LOCATION (City, town, or county) Ritchie Highway | | 24E. DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | | 24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D. | |
| 25. FUNERAL DIRECTOR KRAUSE FUNERAL HOME | | 25A. ADDRESS 1216 S. Charles St. Balto. 30 Md. | | 67084 | |



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 7430

BIRTH NO. 50 7430

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) Dewey Bafford | | | 2. DATE OF DEATH Aug 26 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BAITIMORE 21-02 | | |
| c. Length of stay in Baltimore Life | | | D. STREET ADDRESS (If rural, give location) 618 Scott St. | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH April 1-1899 | 9. AGE (In years last birthday) 51 | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY BROOM FACTORY | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JAMES - BAFFORD | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 212-01-2084 | 17. INFORMANT ADDRESS Mrs Viola Bafford 618 Scott St | | |

| | |
|--|---|
| 18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion Myocardial Infarct | CAUSE OF DEATH (A) Coronary Occlusion DUE TO Myocardial Infarct (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |

| | | |
|--|---|--|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I certify that I took charge of the remains described above, held an _____ thereon and from _____ the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| | | |
|--|--|---|
| 23A. SIGNATURE William Updegraff | 23B. CHIEF MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR | 23C. DATE SIGNED Aug 27 1950 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE August 30-1950 | 24C. NAME OF CEMETERY OR CREMATORY Holy Cross |
| 24D. LOCATION (City, town, or county) (State) ANNE - A Rundle - Co. Md | 25. FUNERAL DIRECTOR ADDRESS Walter T. Schlemmer 1626 W. Ross St | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | REGISTRAR'S SIGNATURE Walter T. Schlemmer | 69032 |

094.1

UNITED STATES OF AMERICA

DEPT. OF JUSTICE

WASHINGTON

OFFICE OF THE ATTORNEY GENERAL

UNITED STATES OF AMERICA

DEPT. OF JUSTICE

WASHINGTON

UNITED STATES OF AMERICA

DEPT. OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL

M 560
50 7431

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7431

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Joseph Monroe

2. DATE
OF
DEATH

August 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

18-02

B. FULL NAME OF HOSPITAL OR INSTITUTION

1107 W. Saratoga St.

Yrs.
Mos.
Days

1107 W. Saratoga St.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

JAN. 22, 1911 39

9. AGE (In years, last birthday)

10. Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction Work

11. BIRTHPLACE (State or foreign country)

Richmond Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES MONROE

14. MOTHER'S MAIDEN NAME

Lucinda Roe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS 105 N. Florence Poindexter Schroeder St.

18.

420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Occlusion

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular

DUE TO

(C) renal dis.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 16, 1950, to Aug. 24, 1950, that I last saw the deceased alive on Aug. 23, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

H. Garland Smith

23B. ADDRESS

402 W. Franklin

23C. DATE SIGNED

8-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Buried

24B. DATE

8-28-1950

24C. NAME OF CEMETERY OR CREMATORY

W. C. Calkins Cem. Balto.

24D. LOCATION (City, town, or county) (State)

MD

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Emmington Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams Schroeder St.

ADDRESS

322 N

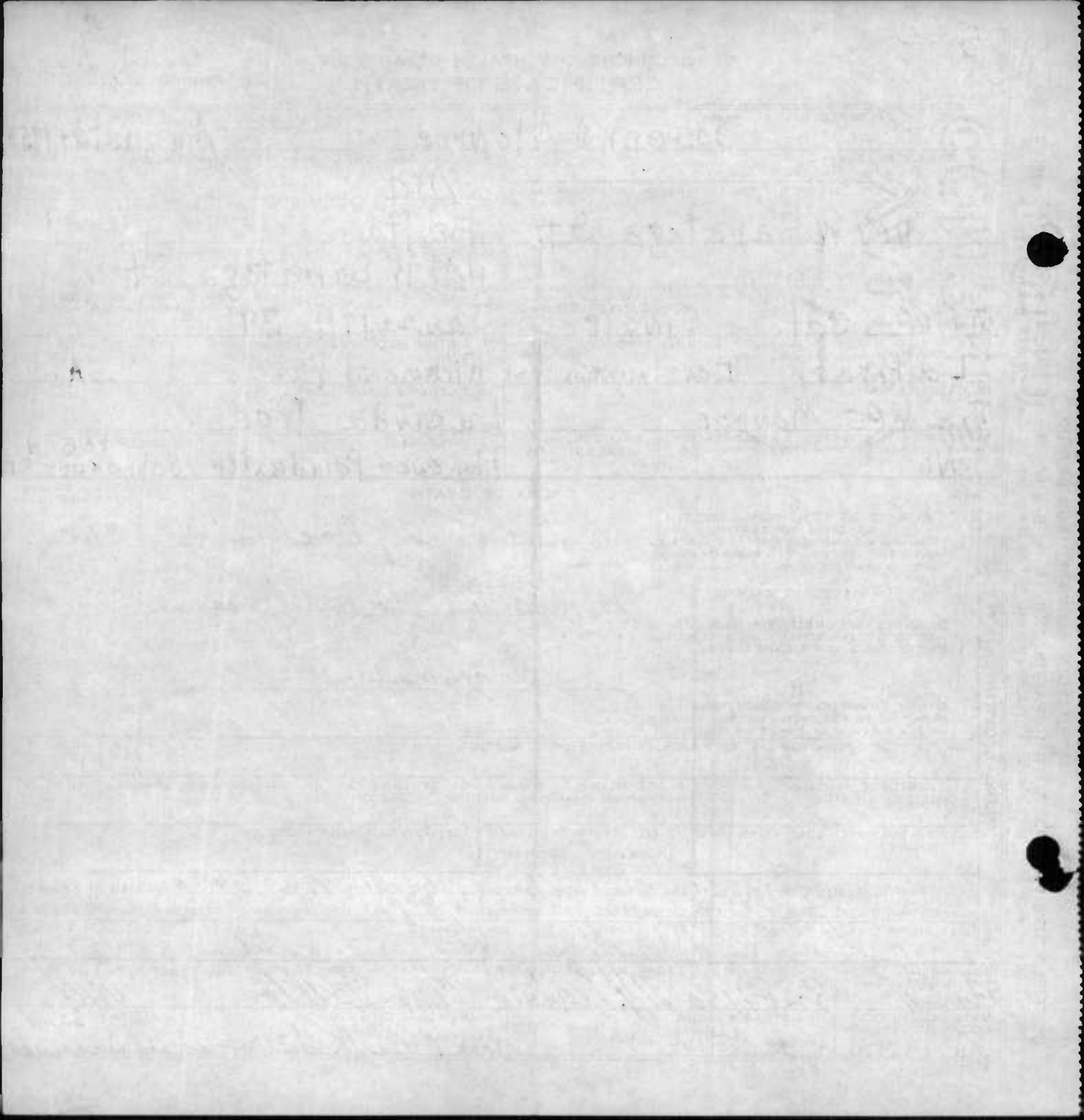
VS 150

97024

131.1

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7432
Aug. 26, 1950

BIRTH NO.

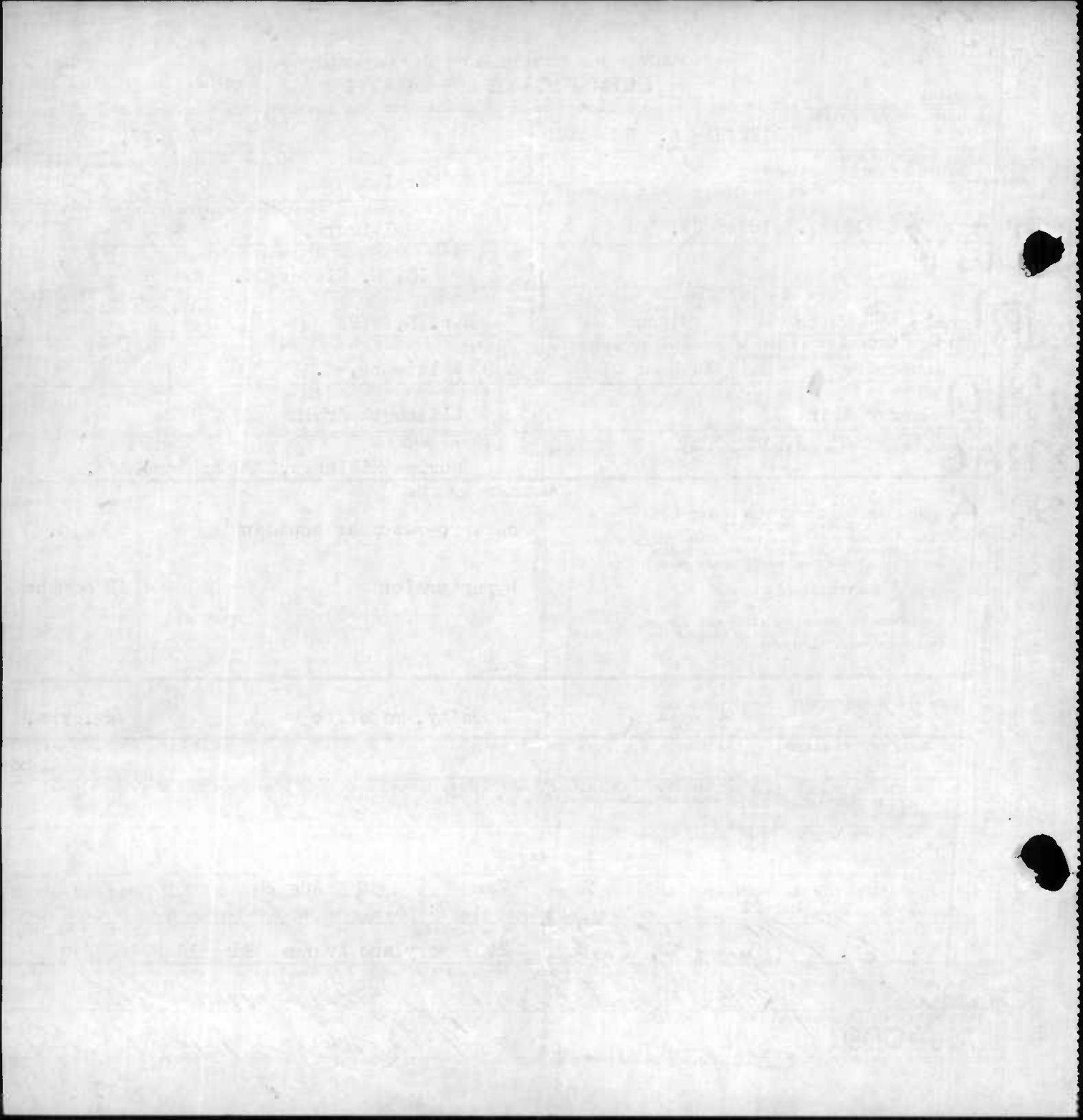
| | | | |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) CHRISTINA A. ROBINSON | | 2. DATE OF DEATH | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-02 | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 137 N. Glover St. | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 137 N. Glover St. | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | B. DATE OF BIRTH Mar. 18, 1879 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | 9. AGE (In years last birthday) 71 If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George Walz | | 14. MOTHER'S MAIDEN NAME Elizabeth Arbin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Maurice Ribinson, 2720 Ashland Ave. | | ADDRESS | |

| | | |
|---|--|--|
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) cerebrp-vascular accident (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 10 min. |
| ANTECEDENT CAUSES hypertension (B) DUE TO | | 12 months |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. obesity, moderate | | sev. yrs. |

| | | | | | |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Jan , 1950, to Aug 26 , 1950, that I last saw the deceased alive on Aug 22 , 1950, and that death occurred at 7:00 a.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE E. Ellsworth, M.D. | | 23B. ADDRESS 2431 Maryland Avenue Bto 18 | | 23C. DATE SIGNED 8/28/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/29/50 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. LOCATION (City, town, or county) Baltimore | | 24F. LOCATION (City, town, or county) Baltimore | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | | REGISTRAR'S SIGNATURE William Williams, M.D. | | 25. FUNERAL DIRECTOR W. Cook Inc | |
| | | | | ADDRESS 1217 St Paul St | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Butschky
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7433

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Eugene W. Butschky

2. DATE
OF
DEATH

8/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Sinai of Baltimore

C. CITY OR TOWN

(If outside corporate limits, write Baltimore and give township)

Balto

24-04

D. STREET ADDRESS (If rural, give location)

1510 Covington St

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12/9/1873

9. AGE (In years
last birthday)

76

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired Machinist

10B. KIND OF BUSINESS OR
INDUSTRY

Sugar Refinery

11. BIRTHPLACE (State or foreign country)

Balto. Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Butschky

14. MOTHER'S MAIDEN NAME

Henrietta Bergin

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

212-09-6381

17. INFORMANT

Anna L. Butschky

ADDRESS

1510 Covington St

18.

470.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Rheumatic + arteriosclerotic
Heart disease

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

BPH 3°

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Hemorrhagic cystitis

INTERVAL BETWEEN
ONSET AND DEATH

?

?

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ ND ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 15, 1950, to Aug. 27, 1950, that I last saw the deceased alive on Aug. 27, 1950, and that death occurred at 2:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Eugene Heller, M.D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

8/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/30/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Balto Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

Wm Cook Inc 1217 St. Paul St.

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 7434

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELMER B. WOOLFORD

2. DATE OF DEATH Aug. 27, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

S. Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
111 W. Lee St.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

1902

9. AGE (In years last birthday)

48

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Hospital Attendant

10B. KIND OF BUSINESS OR INDUSTRY
State Hospitals

11. BIRTHPLACE (State or foreign country)
Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Woolford

14. MOTHER'S MAIDEN NAME

Margaret Rawlings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
John W. Cook, 1617 Marshall St.

18.

002X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH
6 mos.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 3, 1950, to Aug 27, 1950, that I last saw the deceased alive on Aug 25, 1950, and that death occurred at 1:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

8/30/50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county) (State)

Glen Burnie, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 28 1950

Huntington Williams, Jr.

1219 St Paul St

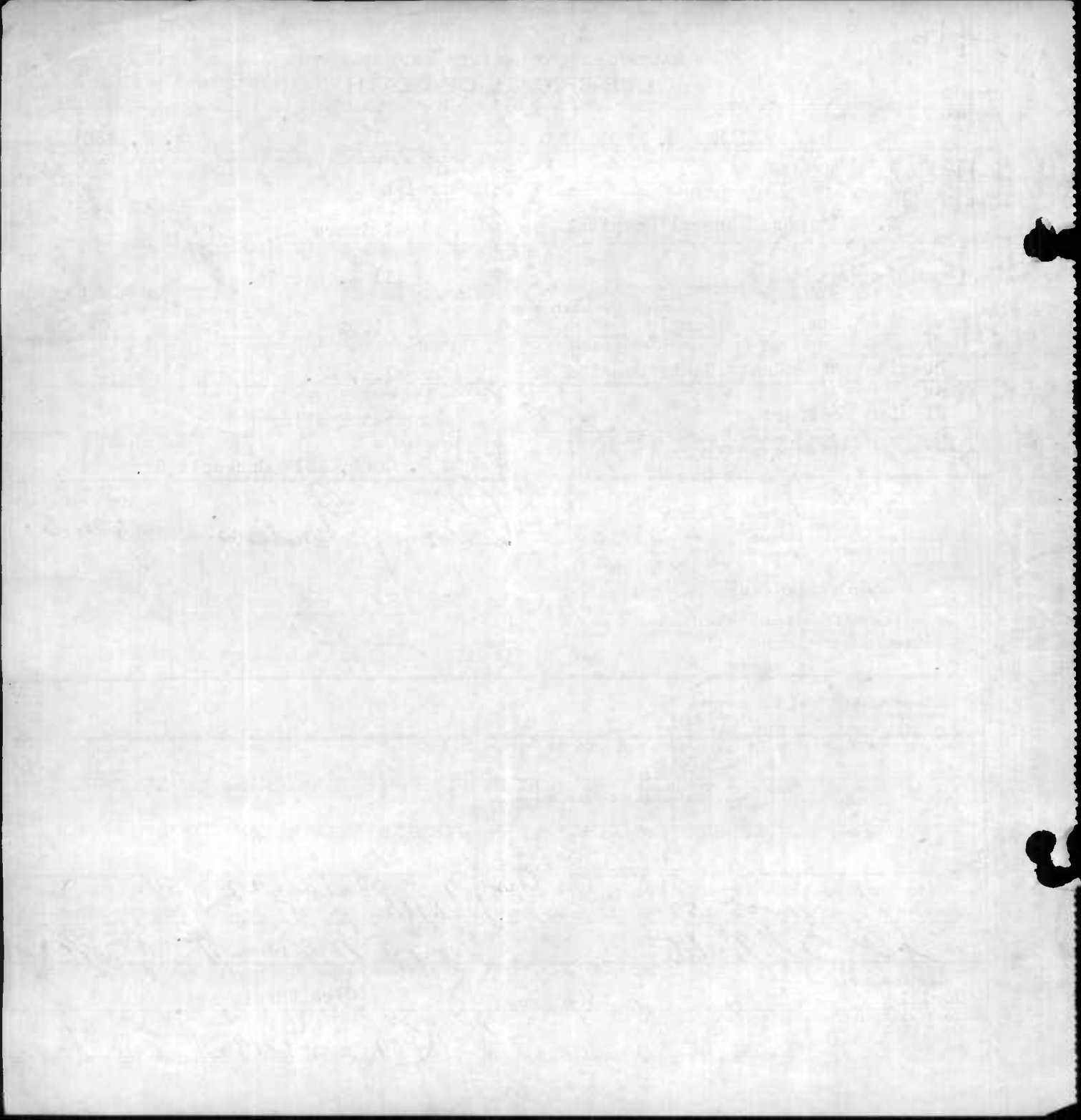
VS 150

7308T

013.2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE IN UNFADING INK. Every item of information should be clearly and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 7435

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Baby Boy Todd-Osabell

2. DATE
OF
DEATH

8-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1305 Harlem Avenue

16-02

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

8-21-50

9. AGE (in years
last birthday)10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

1

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Bernard Hawkins

14. MOTHER'S MAIDEN NAME

Osabell Todd

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records* Balto. City Hospitals Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Prenaturity

(A)
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

1 Day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)

Fetal Atelectasis

1 Day

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 8-21 1950 to 8-22 1950, that I last saw the
deceased alive on 8-22 1950 and that death occurred at 10:50 P. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

4940 Eastern Avenue

8-25-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Cremation

24B. DATE

8-25-50

24C. NAME OF CEMETERY OR CREMATORY

B.C.H. CREMATORY

24D. LOCATION (City, town, or county)

(State)

4940 Eastern Ave. Balto. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

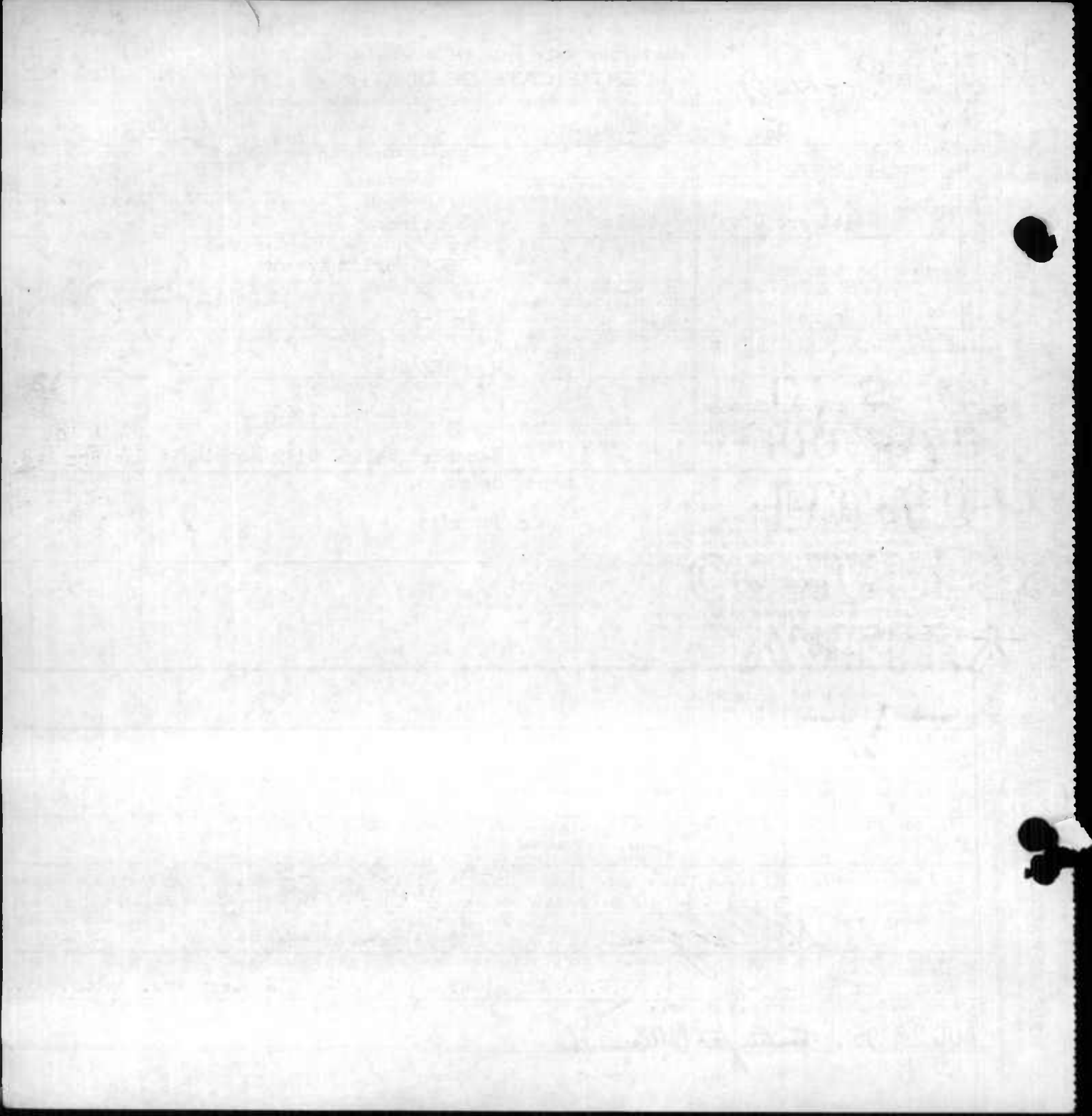
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 28 1950

Therington Williams, M.D.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7436

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Olivia G. Harrison

2. DATE
OF
DEATH

August 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONThe Gundry Sanitarium
Rt. 1, Baltimore 29, Md.C. CITY OR TOWN. (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6313 6313 Weidner Ave.

c. Length of stay in Baltimore

91

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Nov. 6, 1859

9. AGE (In years
last birthday)

91

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James Clinton Harrison

14. MOTHER'S MAIDEN NAME

Sarah Jane Trogler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Miss Esther Anne Harrison

ADDRESS

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

24 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) hypertension

DUE TO

years

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) arteriosclerosis, general + cerebral

years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from August 19, 1950, to August 28, 1950, that I last saw the
deceased alive on August 28, 1950, and that death occurred at 10:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Rudolf H. Gundry

M. D.

23B. ADDRESS

The Gundry Sanitarium Rt. 1, Baltimore

23C. DATE SIGNED

8-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8 - 30 - 50

24C. NAME OF CEMETERY OR CREMATORY

Govans Presbyterian

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

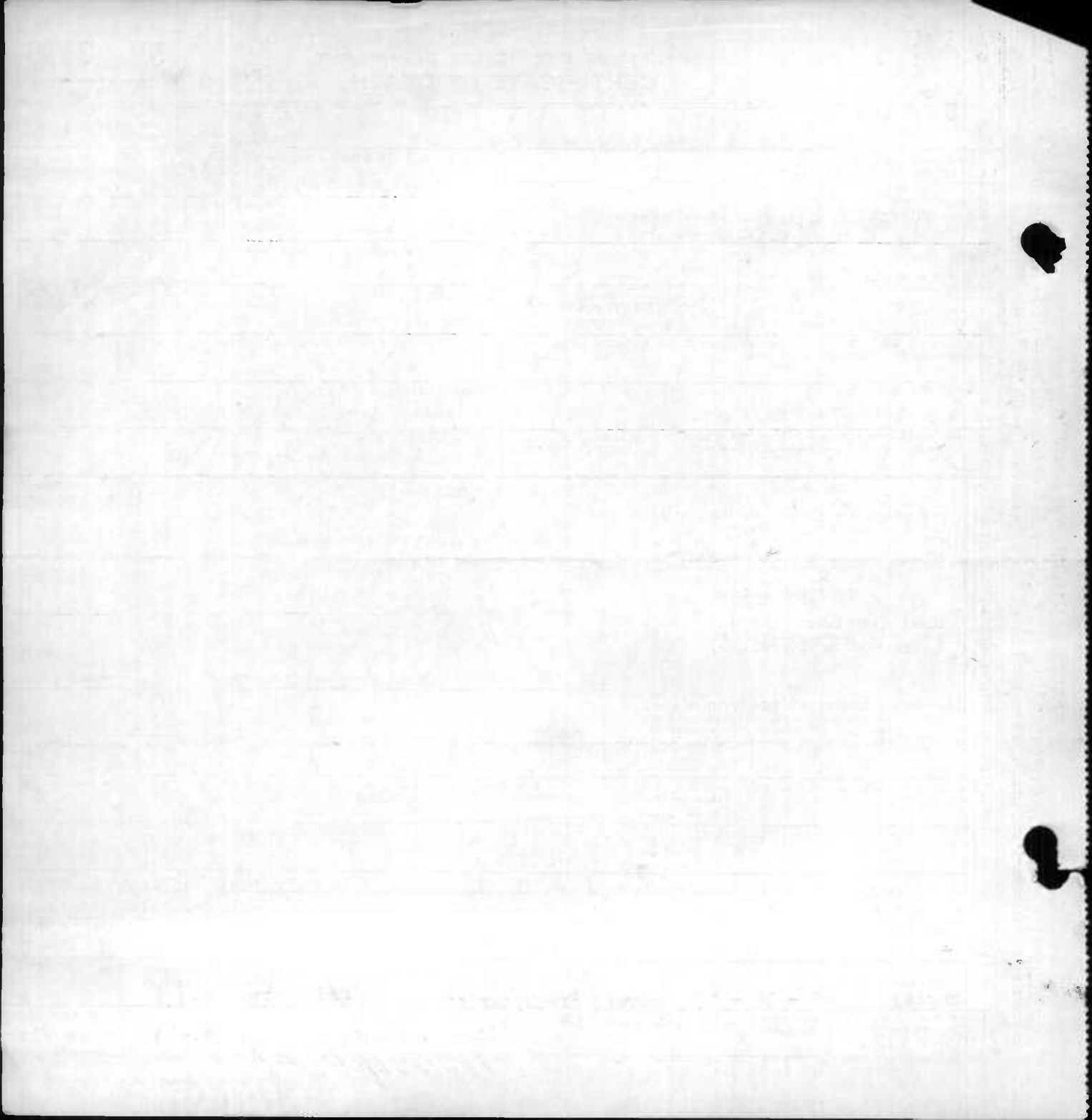
Timothy J. Harrison, M.D.

25. FUNERAL DIRECTOR

John O. Mitchell & Sons Inc.-1900 Eutaw Place

ADDRESS

AUG 28 1950



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Rosa Mickey

2. DATE
OF
DEATH

Aug 26, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
A. STATE B. COUNTY before admission)

Ind -

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Turners Station

D. STREET ADDRESS (If rural, give location)

101 Walnut Ave. 53-00

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female Negro

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7-25-95

9. AGE (in years
last birthday)

50

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wm. Lineth

14. MOTHER'S MAIDEN NAME

Eliz Hummel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMATION JOHNS HOPKINS HOSPITAL ADDRESS

18.

464 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary embolus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Phlebotrombosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Constrictive pericarditis or effusion

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 24, 1950 to Aug 26, 1950, that I last saw the
deceased alive on Aug 26, 1950, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas J. Walck

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-26-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 30-1950

24C. NAME OF CEMETERY OR CREMATORY

Beltsville Memorial Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston William, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Samuel W. Sullivan & Co.

1011 N. Calverton Ave. 100.2

Aug 20, 20

John H. H. H.

John

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7438

Registered No. _____

BIRTH NO. _____

| | | | | | |
|--|----------------------------------|--|---|--|---|
| 1. NAME OF DECEASED (Type or Print) John J. Callahan | | | 2. DATE OF DEATH Aug 26, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived at institution: residence before admission) A. STATE MD. B. COUNTY _____ | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION University Hospital | | | C. CITY OR TOWN (If outside corporate limits, write full name and give township) Balto. 22-01 | | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | | D. STREET ADDRESS (If rural, give location) 509 Hanover St | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH JUN 21, 1871 | 9. AGE (In years last birthday) 79 | If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Watchman | 11. BIRTHPLACE (State or foreign country) County Brk-Ireland | | 12. CITIZEN OF WHAT COUNTRY? _____ |
| 13. FATHER'S NAME James Callahan | | | 14. MOTHER'S MAIDEN NAME Mary | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT ADDRESS Geo. L. Callahan 3324 Reisterstown Rd. Pk. | | |

| | | |
|--|---|--|
| 18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH (A) Pulmonary embolus DUE TO _____ (B) Carcinoma of the prostate DUE TO _____ (C) _____ | INTERVAL BETWEEN ONSET AND DEATH 0 |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. _____ _____ _____ | | |

| | | |
|--|--|---|
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____ _____ _____ | | |
| 19A. DATE OF OPERATION Aug 24, 1950 | 19B. MAJOR FINDINGS OF OPERATION Prostatic enlargement | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | 21B. PLACE OF INJURY (e. g., at or about home, farm, factory, street, office bldg., etc.) _____ | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____ |

22. I hereby certify that I attended the deceased from **Aug. 20**, 19**50**, to **Aug 26**, 19**50**, that I last saw the deceased alive on **Aug 26**, 19**50** and that death occurred at **4:00** p. m., from the causes and on the date stated above.

| | | | | |
|---|-----------------------------|---|--|---|
| 23A. SIGNATURE Raymond Bradshaw, Jr. M.D. | | 23B. ADDRESS University Hospital | | 23C. DATE SIGNED Aug 26, 1950 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Buried | 24B. DATE 8/29/50 | 24C. NAME OF CEMETERY OR CREMATORY St. Peter's | 24D. LOCATION (City, town, or county) (State) Baltimore MD | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | |
| 25. FUNERAL DIRECTOR McCoy | | ADDRESS 1219 St Paul St | | |

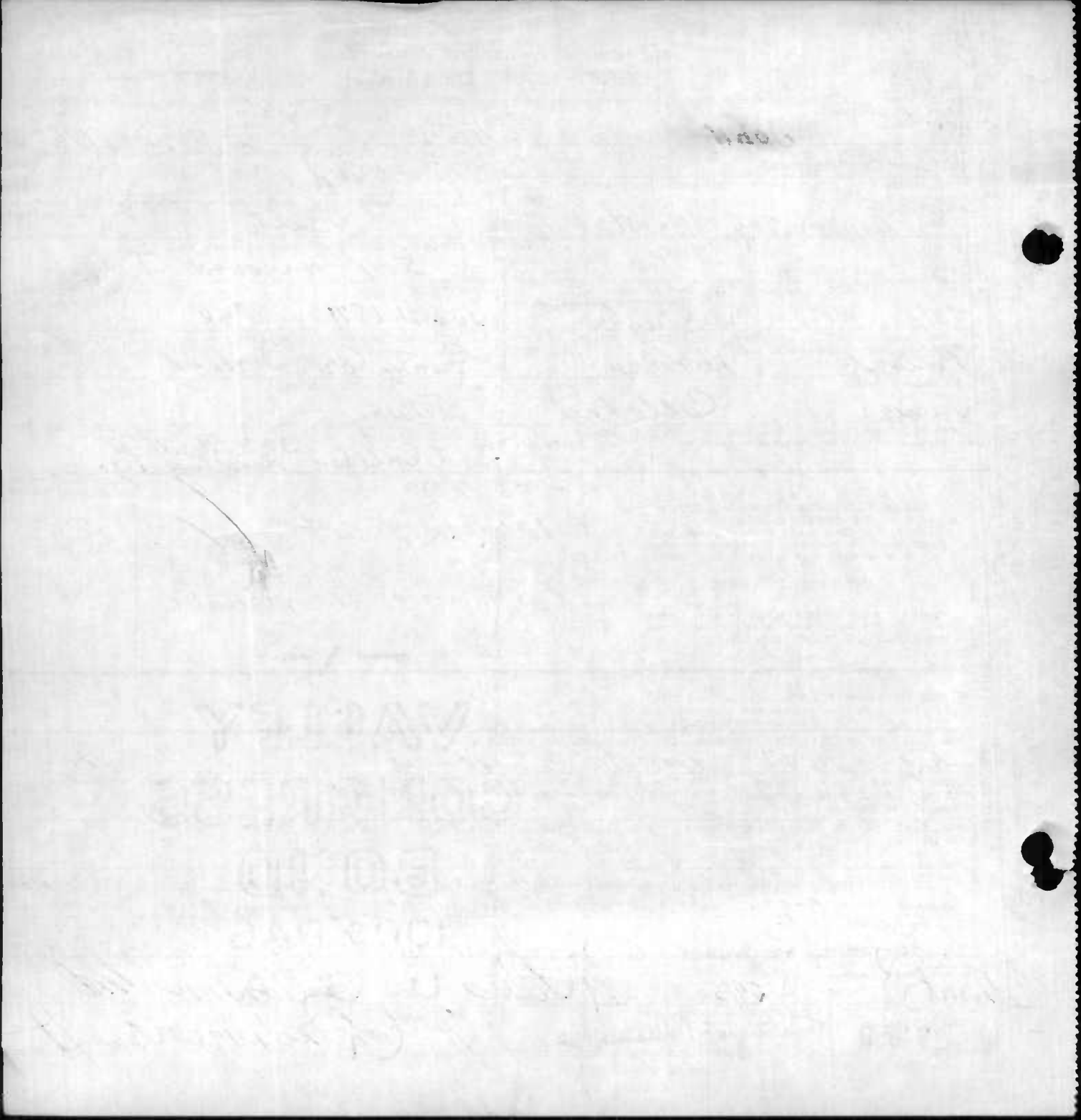
VS 150

051.2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 7439

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Oliver Hind

2. DATE
OF
DEATH

Aug 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Dist. 6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Pen. Mar., Pa.

D. STREET ADDRESS (If rural, give location)

V-35

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9-3-86

9. AGE (in years
last birthday)

63 yrs

H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

FISHERMAN

10B. KIND OF BUSINESS OR
INDUSTRY

COMMERCIAL

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas F. Hind

14. MOTHER'S MAIDEN NAME

Ida Shook

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHN HOPKINS HOSPITAL ADDRESS

18.

465X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Pulmonary Embolus

3-5d-

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-26-1950 to 8-26-1950 that I last saw the
deceased alive on 8-26-1950 and that death occurred at 1:25 P.M., from the causes and on the date stated above.

23A. SIGNATURE

David Lukens

M. D.

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

8-26-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

8/27/50

24C. NAME OF CEMETERY OR CREMATORY

George Town

24D. LOCATION (City, town, or county)

George Town, Fla.

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tucker & Sons Balto.

ADDRESS

Md.

52-E 19

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Lochary
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7440

BIRTH NO. 50-18449

1. NAME OF DECEASED
(Type or Print) *Lochary, Baby Girl*

2. DATE
OF
DEATH *Aug. 26-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *BALTIMORE*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE *16 SOMERSET Maryland*
B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION *MERCY*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Catonville, Md.

c. Length of stay in Baltimore *1 1/2 days*

D. STREET ADDRESS (If rural, give location)
16 SOMERSET Rd.

5. SEX *F*

6. COLOR OR RACE *W*

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Infant

8. DATE OF BIRTH
AUG 25, 1950

9. AGE (In years
last birthday) *+*

10. Under 1 Year
Months: Days
1 12 Hrs.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)
Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.

13. FATHER'S NAME
Joseph Lochary

14. MOTHER'S MAIDEN NAME
MARY WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO. *773.5*

17. INFORMANT
MOTHER

ADDRESS
SAME

18. *773.5*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug 25, 1950* to *Aug 26, 1950*, that I last saw the
deceased alive on *Aug 26, 1950* and that death occurred at *3:15 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE
Thom E. Matthews

23B. ADDRESS
16 Somerset

23C. DATE SIGNED
August 27, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
burial

24B. DATE
Aug. 28, 1950

24C. NAME OF CEMETERY OR CREMATORY
Mt. Olivet

24D. LOCATION (City, town, or county) (State)
Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR
AUG 28 1950

REGISTRAR'S SIGNATURE
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

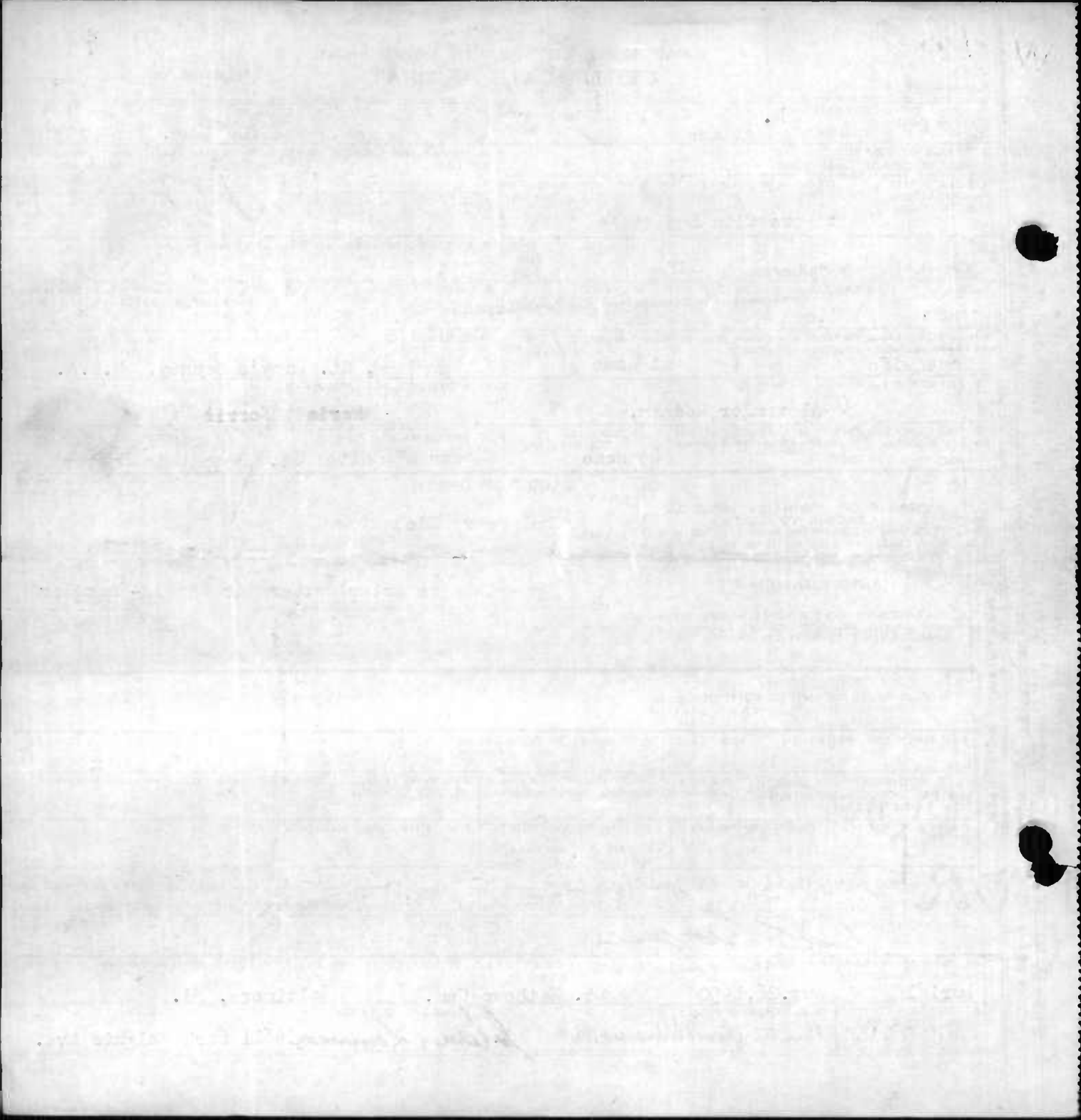
6-Vernon & Company, 4611 Park Heights.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7441

| | | | |
|--|---|---|---|
| 1. NAME OF DECEASED (Type or Print) M. Jennie Wallace | | 2. DATE OF DEATH Aug. 26, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| c. Length of stay in Baltimore Life | | D. STREET ADDRESS (If rural, give location) 3131 Sumter Avenue | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 15, 1965 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | 9. AGE (In years last birthday) 85 If Under 1 Year: Months: Days: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) Maryland, St. Mary's County, U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME (D) Alexander Redman, | | 14. MOTHER'S MAIDEN NAME (D) Maria Norris | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Records* Balto City Hospitals Eastern Ave | | ADDRESS 4940 | |
| 18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema DUE TO (A) Pulmonary Edema (B) Hypertensive Arteriosclerotic Cardio-Vascular Disease DUE TO (C) over 1 Yr. | | INTERVAL BETWEEN ONSET AND DEATH 4 Days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 7 | | 19B. MAJOR FINDINGS OF OPERATION | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 8-22 , 19 50 to 8-26 , 19 50 , that I last saw the deceased alive on 8-26 , 19 50 and that death occurred at 10:45 A.M. from the causes and on the date stated above. | | | |
| 23A. SIGNATURE Ch. Cohen M. D. | | 23B. ADDRESS 4940 Eastern Avenue | |
| 23C. DATE SIGNED 8-26-50 | | 24. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) burial | 24B. DATE Aug. 28, 1950 | 24C. NAME OF CEMETERY OR CREMATORY St. Mathews Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1950 | REGISTRAR'S SIGNATURE Wm. H. Williams, M.D. | FUNERAL DIRECTOR Vernon L. Lamm ADDRESS 4611 Park Heights Ave. | |



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

50 7442

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Howard Hargett

2. DATE
OF
DEATH

Aug. 26th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

2304 W. Baltimore St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 20-02

C. Length of stay in Baltimore

32 Yrs.

O. STREET ADDRESS (If rural, give location)

2304 W. Baltimore St.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

Dec. 7, 1869

9. AGE (In years last birthday)

81

If Under 1 Year Months: Days
8 19

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Helper

10B. KIND OF BUSINESS OR INDUSTRY
B.O.R.R.

11. BIRTHPLACE (State or foreign country)

Frederick, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Richward W. Hargett

14. MOTHER'S MAIDEN NAME

Sarah Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mary A. Hargett, 2304 W. Baltimore St.

18. 4221

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Arteriosclerotic Cerebrovascular Disease*
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Smoking*
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/24, 1950, to 8/26, 1950, that I last saw the deceased alive on 8/26, 1950, and that death occurred at 3:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Harold Langhorne

M. D.

23B. ADDRESS

4508 Edmondson Village

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

Aug. 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county) (State)

Frederick, Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

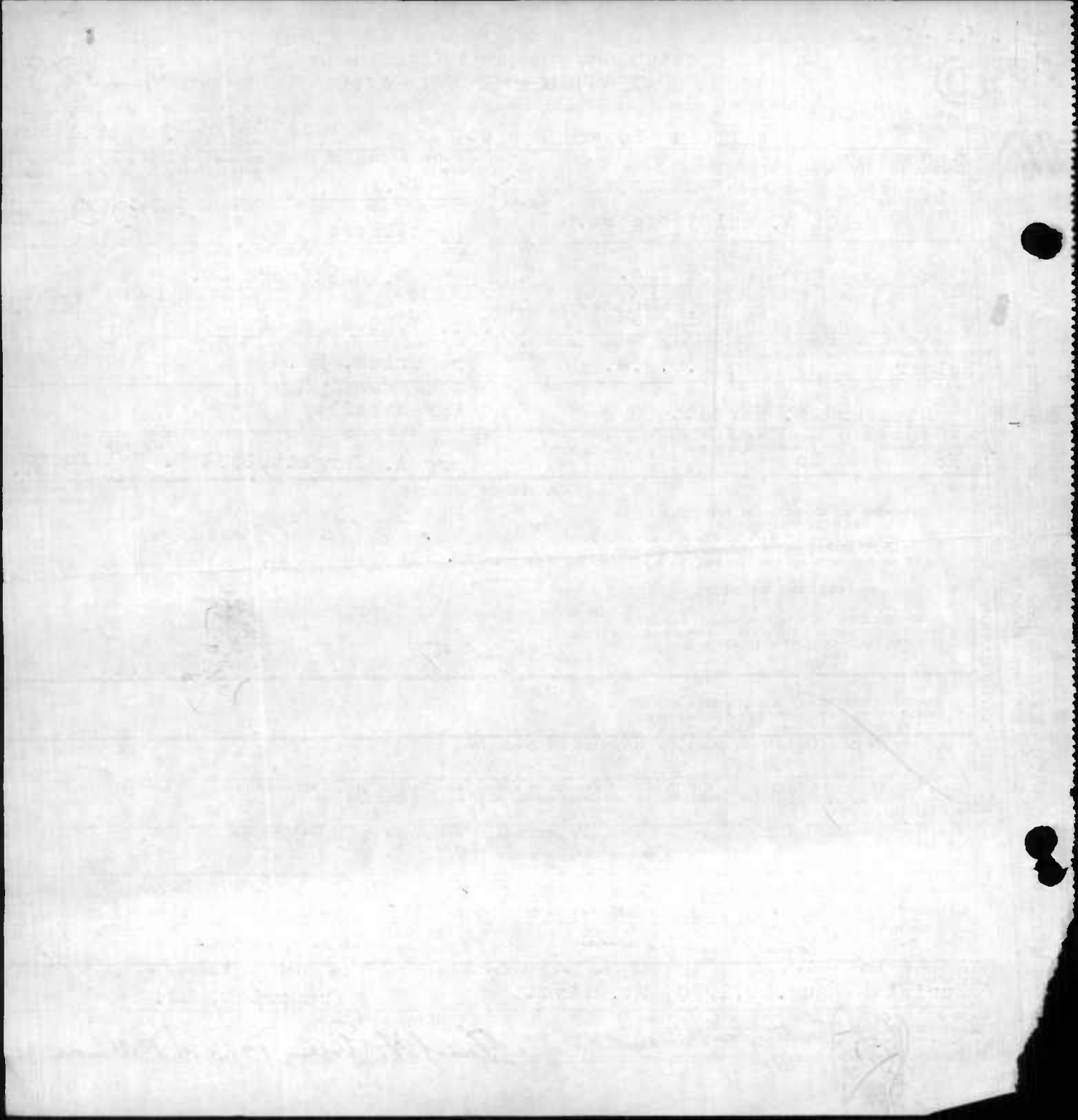
25. FUNERAL DIRECTOR

ADDRESS

Fred. A. Cole, 1913 W. Baltimore St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Florence E. Bevins

2. DATE
OF
DEATH

8.25.50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

DCA
BALTIMORE E. N. T. HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, MD - 8-03

D. STREET ADDRESS (If rural, give location)

2730 East Preston.

C. Length of stay in Baltimore

5-8 yrs.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow.

8. DATE OF BIRTH

June 14, 1892 38

9. AGE (In years last birthday)

10. Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore -

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thos. Kerr.

14. MOTHER'S MAIDEN NAME

Anna Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Anna Johnson (Daughter)

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Massive Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Carcinoma larynx
(metastatic)
Emergency Tracheotomy
& X-Ray therapy.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

May 6, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma larynx

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Aug 25, 1950, that I last saw the deceased alive on Aug 10, 1950, and that death occurred at 4 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Frank R. Geyer J.

23B. ADDRESS

BALD ENT Hoop.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

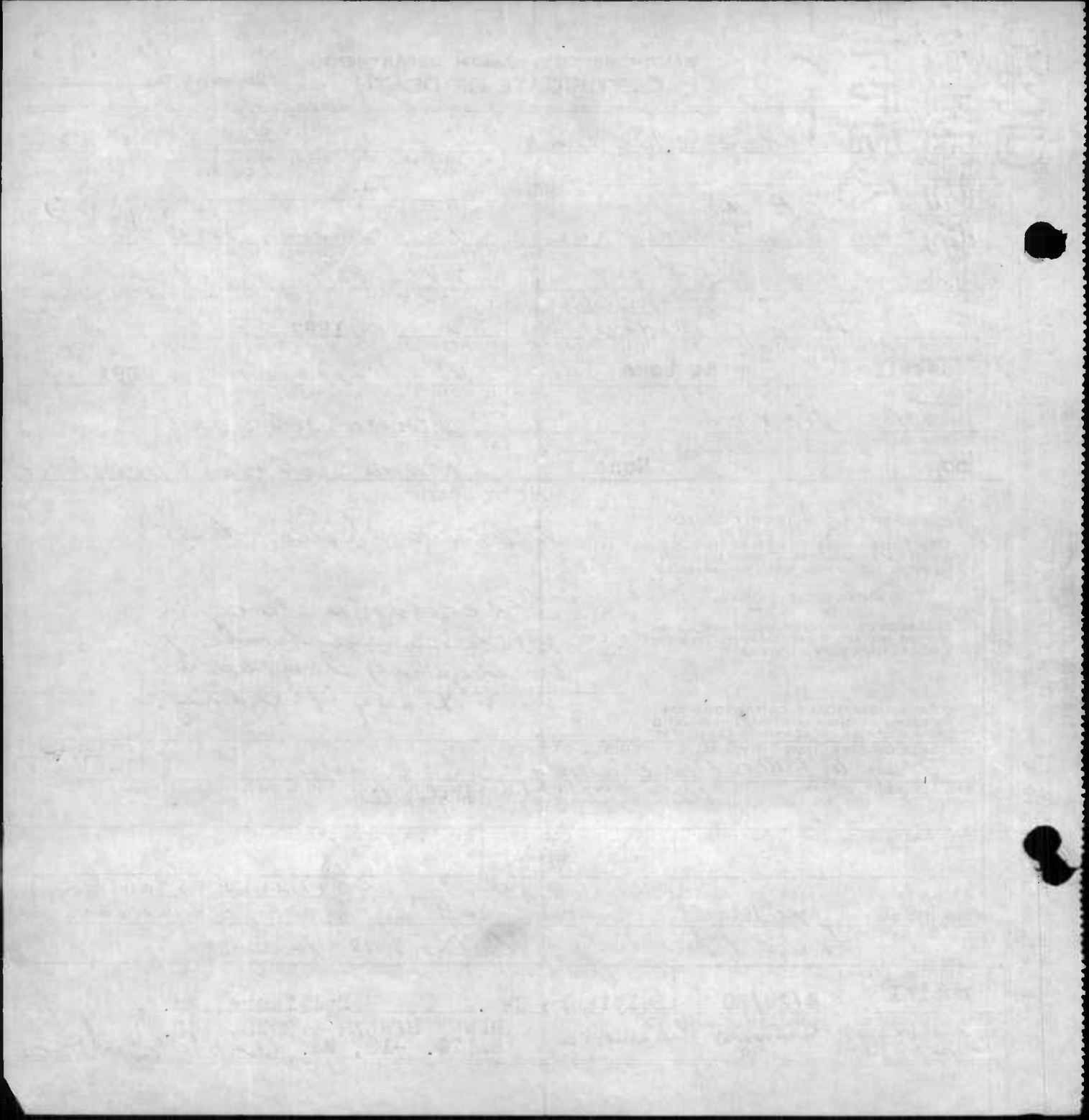
ATTEST: CLERK OF HEALTH DEPARTMENT

HENRY SANDER & SONS, INC.

BALTO. -13, Md.

ADDRESS

1311 S. E. 1st St.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7444
Registered No. _____

BIRTH NO. 50 7444

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Lillian Frances Seal | | | 2. DATE OF DEATH August 26, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 3617 Buena Vista Avenue | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| C. Length of stay in Baltimore 15 years | | | D. STREET ADDRESS (If rural, give location) 3617 Buena Vista Avenue | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 18, 1899 | | 9. AGE (In years last birthday) 51 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME Andrew Russell Mills | | | 14. MOTHER'S MAIDEN NAME Missouri Gardner | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or uokooow) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS James A. Seal 3617 Buena Vista Avenue | | |

| | | | |
|--|--|--|----------------------------------|
| 1B. 416X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES | | (A) Cerebral thrombosis | min |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) Auricular fibrillation | 4 yrs. |
| | | (C) Chronic Rheumatic heart disease | 40 yrs. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| | | | | | |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug 1948 to Aug 28, 1950 that I last saw the deceased alive on Aug 22, 1950 and that death occurred at 1 P. m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Thomas R. Freeman | | 23B. ADDRESS 11 W. 29th ST. | | 23C. DATE SIGNED Aug 28, 1950 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 29, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park | |
| 24D. LOCATION (City, town, or county) Baltimore Co., Maryland | | 25. FUNERAL DIRECTOR'S ADDRESS Burgee Funeral Home 3631 Falls Road | | | |

Mr. Norman R. Freeman Jr.,
11 S. 29th St. No. 7356
St Paul, Conn. No. 7361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

| | | | |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) RAY | | 2. DATE OF DEATH August 27, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middle River | |
| c. Length of stay in Baltimore | | D. STREET ADDRESS (If rural, give location) 918 Garden Road | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 2/24/1910 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker | | 10B. KIND OF BUSINESS OR INDUSTRY Steel Mills | 9. AGE (In years last birthday) 40 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Lonny. Ayers. | | 14. MOTHER'S MAIDEN NAME Emma Maye Wardrup | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 40070-4664 | |
| 17. INFORMANT Lonny. Ayers | | ADDRESS 918 Garden Drive | |

| | | |
|---|--|----------------------------------|
| 18. E900.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Intracranial hemorrhage DUE TO (A) Fracture of skull (B) Fracture of skull (C) Fracture of skull | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Fracture of skull (C) Fracture of skull | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Industrial place | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rolling Mill Avenue Eastern Stainless Steel Company | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 27, 1950 11:15P m. | | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell down outside steel steps | |
| 22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | | |
| 23A. SIGNATURE Stanley B. Dureacher | | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> | | 23C. DATE SIGNED 8-28-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/31/1950 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Balto Co Md | | 24E. FUNERAL DIRECTOR J. J. Brydinski | | ADDRESS 1407 Eastern Ave. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1950 | | REGISTRAR'S SIGNATURE Wm. H. Williams | | | |

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7446
Registered No. _____

BIRTH NO. _____

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Mr. Edward Kimmel</i> | | | 2. DATE OF DEATH <i>8/28/50</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____ | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agnes Hospital</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 25.52</i> | | |
| c. Length of stay in Baltimore <i>Life</i> | | | D. STREET ADDRESS (If rural, give location) <i>2001 Casadel-Cre</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>9/2/1875</i> | | 9. AGE (In years last birthday) <i>74</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Lloyd E. Mitchell</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Frank C. Kimmel</i> | | | 14. MOTHER'S MAIDEN NAME <i>Anna Grubert</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | 17. INFORMANT <i>Mr Frank C. Kimmel</i> ADDRESS <i>2001 Casadel-Cre</i> | | |

| | | |
|--|---|----------------------------------|
| 18. <i>151X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH (A) <i>Carcinoma of Stomach</i> DUE TO <i>multiple metastases</i> (B) <i>Myocarditis</i> DUE TO <i>Rheumatic Endocarditis</i> (C) <i>Arteriosclerosis</i> | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | | | |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION <i>2</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>8/24</i> , 19 <i>50</i> , to <i>8/28</i> , 19 <i>50</i> that I last saw the deceased alive on <i>8/28</i> , 19 <i>50</i> and that death occurred at <i>1230</i> p. m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>John C. Healy</i> M. D. | | 23B. ADDRESS <i>St. Agnes</i> | | 23C. DATE SIGNED <i>8/28/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/31/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>London Park Cem.</i> | |
| 24D. LOCATION (City, town, or county) <i>3801 Frederick Ave</i> | | 24E. LOCATION (State) <i>St.</i> | | | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 29 1950</i> | | REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | | 25. FUNERAL DIRECTOR <i>John J. Bowman & Son</i> | |
| | | | | ADDRESS <i>2001 Casadel-Cre</i> | |

VS 150

57424

046.2

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PRESTON SMITH SINCLAIR

2. DATE
OF
DEATH

Aug. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE US Marine Hospital
Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-10

D. STREET ADDRESS (If rural, give location)

707 Mc Cabe Avenue

c. Length of stay in Baltimore

?

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/28/95

9. AGE (In years last birthday)

54

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Maryland Casualty Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Sinclair

14. MOTHER'S MAIDEN NAME

Lavina Meekin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

212-10-3168

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18.

420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

CAUSE OF DEATH

Myocardial infarction due to coronary sclerosis with occlusion

INTERVAL BETWEEN ONSET AND DEATH

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 27, 1950, to Aug. 27, 1950, that I last saw the deceased alive on Aug. 27, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

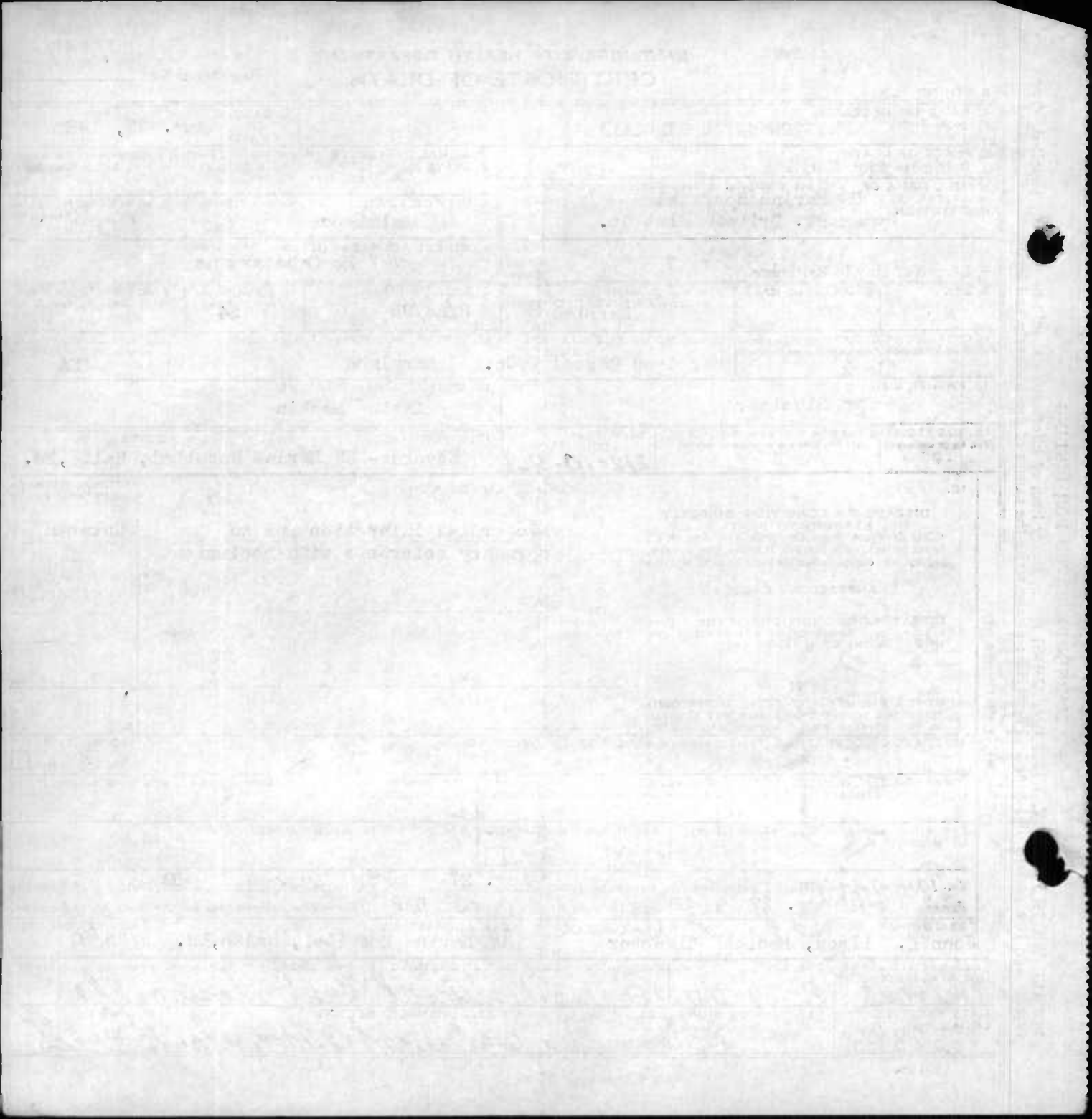
25. FUNERAL DIRECTOR

ADDRESS

AUG 29 1950

Huntington Williams, Jr.

Stewart Morris, Balto.



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7448 29

BIRTH NO. 50 7448 29-58929

1. NAME OF DECEASED (Type or Print) **Richard Martin A-80154**

2. DATE OF DEATH **AUG 28 1950**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHN HOPKINS HOSPITAL

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 3-02

7. STREET ADDRESS (If rural, give location)
817 E. Pratt St.

8. Length of stay in Baltimore
Yrs. Mos. Days

9. SEX **male**

10. COLOR OR RACE **negro**

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
S.

12. DATE OF BIRTH **9-13-46**

13. AGE (in years last birthday) **3**

14. Under 1 Year Months: Days

15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country)
Md.

19. CITIZEN OF WHAT COUNTRY?

20. FATHER'S NAME **Jacob Martin**

21. MOTHER'S MAIDEN NAME **Ida**

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

23. SOCIAL SECURITY NO.

24. INFORMANT **JOHN HOPKINS HOSPITAL**

25. ADDRESS

18. **E 885.0**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Lead Poisoning & Encephalitis (Lead)**

DUE TO

ANTECEDENT CAUSES

(B) **CERTIFICATION APPROVED BY**

DUE TO **Russell S. Fisher M.D.**

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **home**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **817 E. Pratt Street 3/2**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **Indeterminate**

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? **Ate paint containing lead**

22. I hereby certify that I attended the deceased from **8-26-1950** to **8-28-1950**, that I last saw the deceased alive on **8-28-1950**, and that death occurred at **2:40 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE **Robert E. Gustafson M.D.**

23B. ADDRESS **JOHN HOPKINS HOSPITAL**

23C. DATE SIGNED **8-28-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **Aug 31-50**

24C. NAME OF CEMETERY OR CREMATORY **White Hall**

24D. LOCATION (City, town, or county) (State) **S. C.**

DATE RECEIVED BY LOCAL REGISTRAR **AUG 29 1950**

REGISTRAR'S SIGNATURE **Huntington Williams, M.D.**

25. FUNERAL DIRECTOR **James A. Hayes**

ADDRESS **6384 John St**

Medical Ex Case To Be approved 78B

N-966.0

1914-15 and 1915-16

1914-15
1915-16



1914-15
1915-16

1914-15

1914-15

1914-15

1914-15

1914-15

ScheuFEle

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7449

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles H. ScheuFele

2. DATE
OF
DEATH

8/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, give RURAL and give township)

23-01

c. Length of stay in Baltimore

O. STREET ADDRESS (If rural, give location)

904 South Charles Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/21

9. AGE (In years
last birthday)

74

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John C. ScheuFele

14. MOTHER'S MAIDEN NAME

Elizabeth Blessing

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

151X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

(A)

Carcinoma of the stomach
metastasis in the liver.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8/23/50

19B. MAJOR FINDINGS OF OPERATION

Extensive carcinoma
of the stomach, ulcerating and metastasizing

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1950, to 8/28, 1950 that I last saw the
deceased alive on 8/26/50 19, and that death occurred at 8 A m., from the causes and on the date stated above.

23A. SIGNATURE

Arlin Charbonneau M.O.

23B. ADDRESS

South Balt. New Hope

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/31/50

24C. NAME OF CEMETERY OR CREMATORY

WESTMINSTER CEM.

24D. LOCATION (City, town, or county)

WESTMINSTER, MD.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

JOHN F. DENNY, INC. 715 LIGHT ST-30

ADDRESS

AUG 29 1950

VS 150

7408F

046.2

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that _____

for and in consideration of the sum of _____ Dollars

to _____ of the County of _____ State of _____

the receipt of which is hereby acknowledged, have granted, sold

and conveyed, and by these presents do grant, sell, convey and

confirm unto the said _____ of the County of _____ State of _____

all that certain _____

together with all and singular the rights and appurtenances in anywise

in anywise by any means in anywise in anywise by any means in anywise

in anywise by any means in anywise by any means in anywise by any means

in anywise by any means in anywise by any means in anywise by any means

in anywise by any means in anywise by any means in anywise by any means

in anywise by any means in anywise by any means in anywise by any means

Rydzewski
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7450
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Rydzewski

2. DATE
OF
DEATH

Aug. 28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1809 Lancaster St

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, give RURAL and give township)

Baltimore

2-03

D. STREET ADDRESS (If rural, give location)

1809 Lancaster St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days
If Under 24 Hours Hours Min.

M

White

Widowed

74

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Antoni Rydzewski

11. BIRTHPLACE (State or foreign country)

Poland.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Zimka.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

John Rydzewski 1809 Lancaster St

18. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertensive Crisis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Atherosclerosis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

Unknown

Unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Robert B. McHadden M.D.

23B. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐

23C. DATE SIGNED

8-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

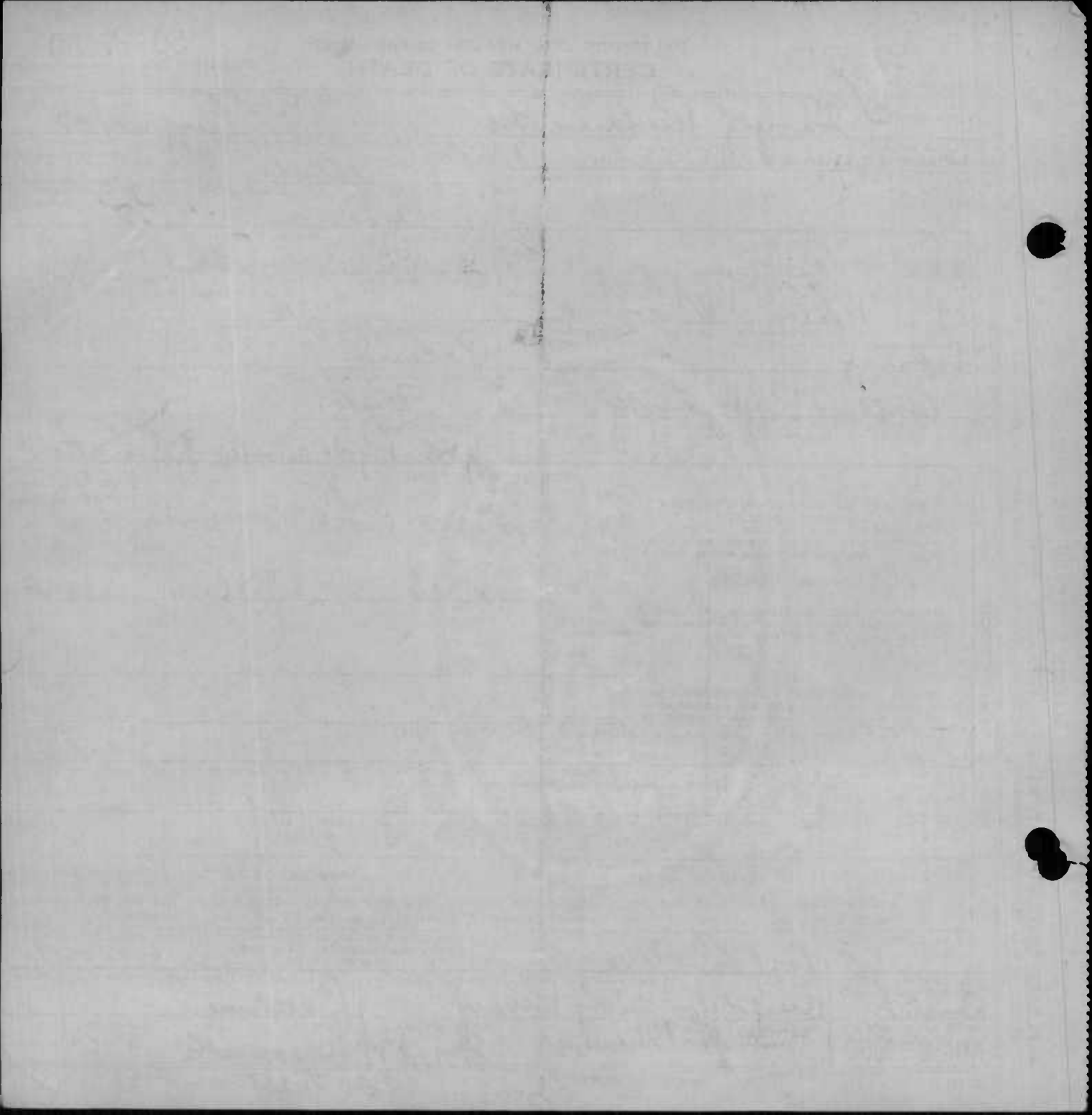
ADDRESS

AUG 29 1950

Huntington Williams, M.D.

Fred W. Ogazowski

093.4



CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7451

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

VITA

JEAN

DUFOR

Defour

2. DATE
OF
DEATH

August 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

12-05

D. STREET ADDRESS (If rural, give location)

1718 1715 N. Calvert St.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Male

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

About 1918

9. AGE (In years last birthday)

32-35

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Oklahoma

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Sgt. Frank Guerras, Central District

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Intracranial hemorrhage due to ruptured aneurysm of internal carotid artery

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Stanley K. Dunsen M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

August 19, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Parkville,

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

AUG 29 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Am. Cook, Inc.

ADDRESS

1217 St. Paul Street

VS 151

96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Color, consistent by phlog
from Medical Examination Office

8.30.50 E. Stenman

Query of aneurysm was
syphilitic & arteriosclerotic
in origin

Probably congenital
J.H. Buckner M.D.

Chambers
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7452

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEON CHAMBERS

2. DATE
OF
DEATH

8/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

PROVIDENT HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

915 SHIELDS PLACE

c. Length of stay in Baltimore

44

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

1893

9. AGE (In years last birthday)

58

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

PERRY CHAMBERS

14. MOTHER'S MAIDEN NAME

JULIA SPENCE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give year or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

KATHAL CHAMBERS 915 SHIELDS

18.

610X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) PULMONARY EMBOLISM

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

48 HRS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

BENIGN PROSTATIC HYPERTROPHY - POST OP

DUE TO

UNKNOWN

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DIABETES MELLITUS

19A. DATE OF OPERATION

8/21/50

19B. MAJOR FINDINGS OF OPERATION

BENIGN PROSTATIC HYPERTROPHY

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/1/50

24C. NAME OF CEMETERY OR CREMATORY

Church Cemetery

24D. LOCATION (City, town, or county)

Farlee, Chestertown Md

DATE RECEIVED BY LOCAL REGISTRAR

AUG 29 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Metropolitan Funeral Home Inc.

927 N. Mount St

1. Name of the plant: *Ficus religiosa* (Fig)
2. Name of the fruit: *Ficus religiosa* (Fig)
3. Name of the seed: *Ficus religiosa* (Fig)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7453

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LILLIE M.

WHEELER

2. DATE
OF
DEATH

8/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, or institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

MARYLAND GENERAL HOSP

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give
township)

BALTIMORE

16-08

D. STREET ADDRESS (If rural, give location)

625 LYNCHURST AVE

c. Length of stay in Baltimore

LIFE

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
widowed

8. DATE OF BIRTH

JUNE 2, 1888

9. AGE (In years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Sales Lady

10B. KIND OF BUSINESS OR
INDUSTRY
Department Store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

DAVID SCHLEIGH

14. MOTHER'S MAIDEN NAME

ELHIRA PLUMMER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, or no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. E. Marriner

ADDRESS

3923 Colbourne Rd.

18.

162X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) CARCINOMATOSIS

DUE TO

6 Mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) POSS. BRONCHIOGENIC CARCINOMA ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/17 1950 to 6/28, 1950, that I last saw the
deceased alive on 6/28, 1950 and that death occurred at 3:20 P. M., from the causes and on the date stated above.

23A. SIGNATURE

L. H. Harold

M. D.

23B. ADDRESS

Maryland General Hosp

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/31/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 29 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Vickers & Sons

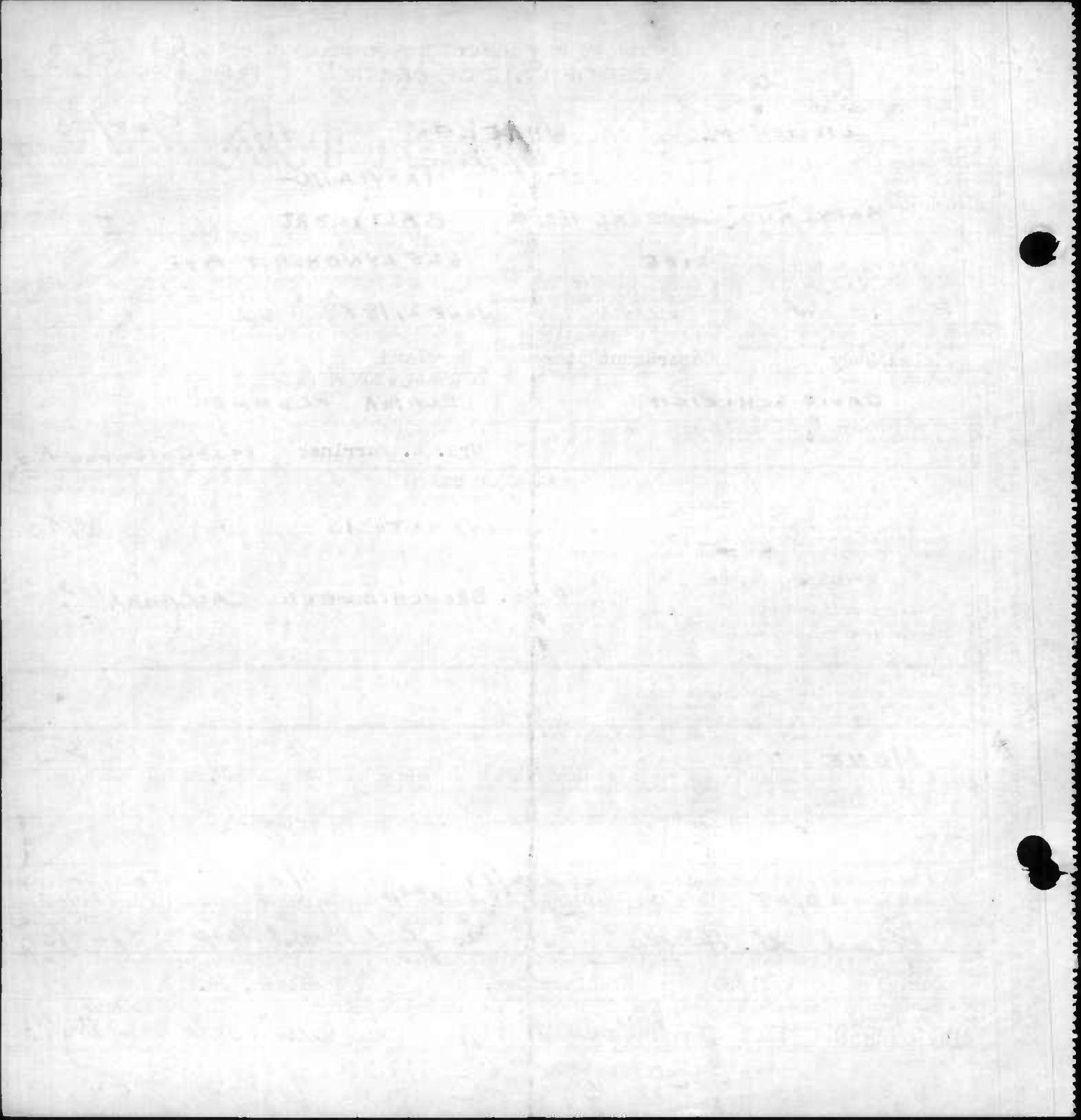
ADDRESS

Baltimore, Md.

VS 150

490 6C

047.3



MARGIN RESERVED FOR BINDING

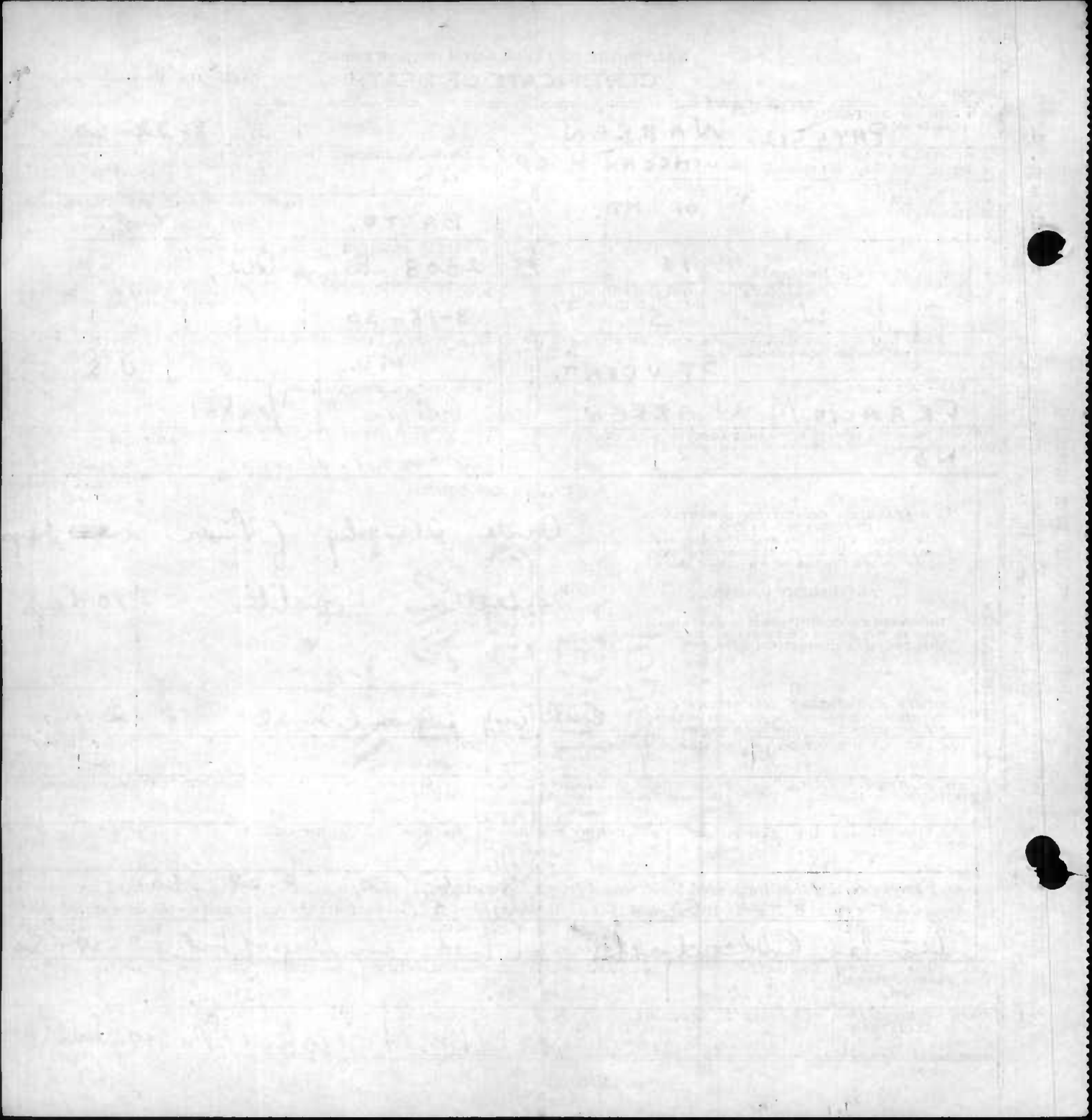
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-650
50 7454

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7454

| | | | | | |
|--|------------------------------|---|------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) FRANCES PHYLLIS WARREN | | 2. DATE OF DEATH 8-28-50 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland LUTHERAN HOSP | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION OF MD. | | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTO. 16-05 | | | |
| c. Length of stay in Baltimore 15 Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 2303 Riggs Ave. | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S | 8. DATE OF BIRTH 3-18-35 | 9. AGE (In years last birthday) 15 | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | 13. FATHER'S NAME FRANCIS M. WARREN | | | |
| 14. MOTHER'S MAIDEN NAME Thelma M. Yeake | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mr. Francis Warren - 2303 Riggs Ave. | | | |
| 18. 092X | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Acute Atrophy of Liver | | INTERVAL BETWEEN ONSET AND DEATH 2-3 days | |
| ANTECEDENT CAUSES | | (B) Infectious hepatitis | | 10 days | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) Epilepsy, grand mal | | 2 yrs. | |
| 19A. DATE OF OPERATION 2 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 8-26 , 19 50 , to 8-28 , 19 50 , that I last saw the deceased alive on 8-28 , 19 50 , and that death occurred at 5 A m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Stanley R. Steinhilber | | 23B. ADDRESS M. D. Lutheran Hosp of Md. | | 23C. DATE SIGNED 8-28-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/31/50 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Md. | | 25. FUNERAL DIRECTOR Wm. J. Lickner & Sons, Balto Md. | | ADDRESS | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7455

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARIA HEIL

2. DATE
OF
DEATH 8/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3520 Hilton Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 24-02D. STREET ADDRESS (If rural, give location)
519 E. Clement St.B. FULL NAME OF
HOSPITAL OR
INSTITUTION
HILTON NURSING HOME

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

7/28/1868

9. AGE (In years
last birthday)

82

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral thrombosis, multiple

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

2 wk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

(B) Cerebral arteriosclerosis

1-2 yr.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 5, 1950, to Aug 26, 1950, that I last saw the
deceased alive on Aug 26, 1950, and that death occurred at 10 P. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
B

24B. DATE

8/30/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 29 1950

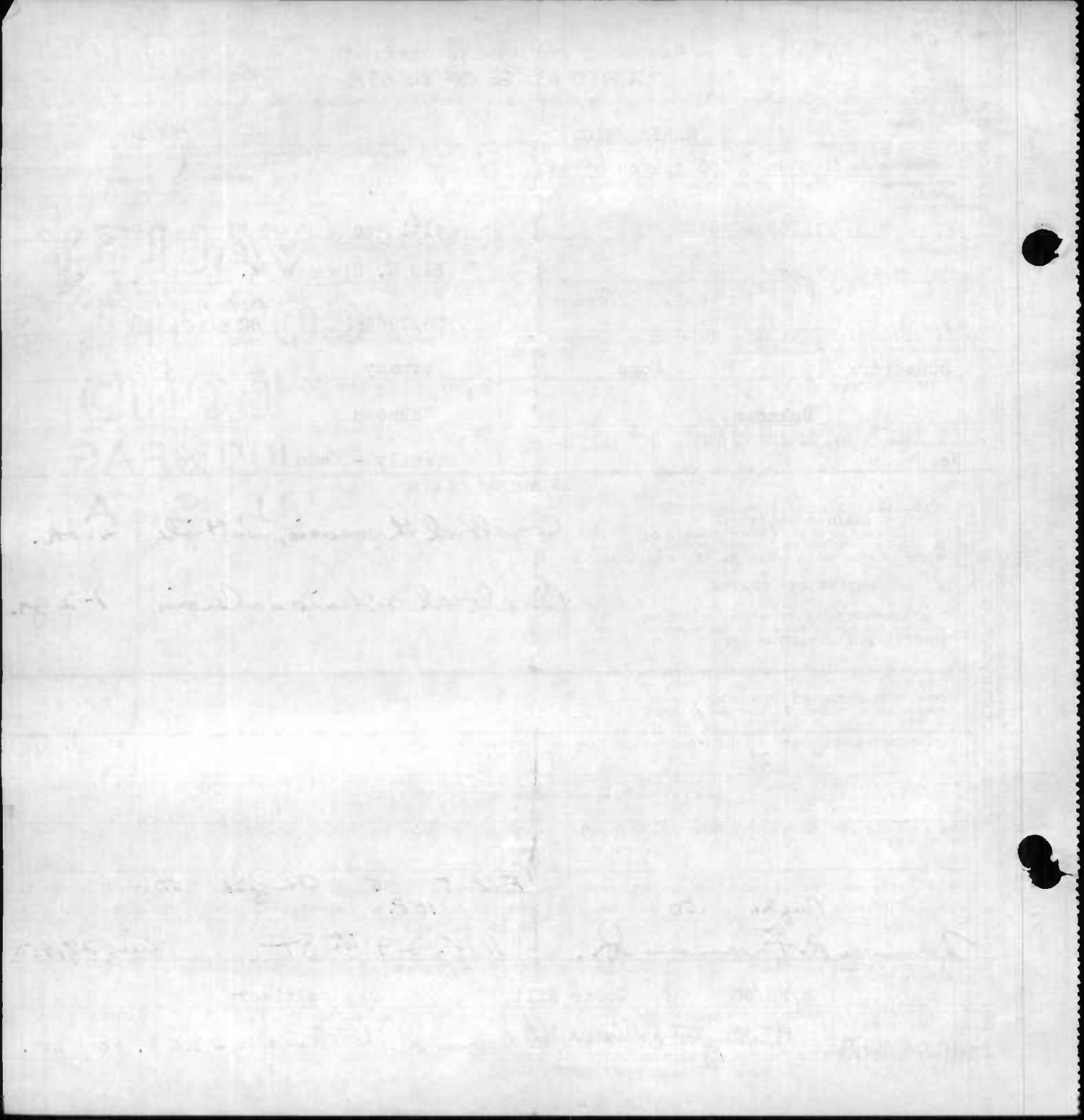
VS 150

- 130 E. Fort Ave.

083.2

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE CORRECTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

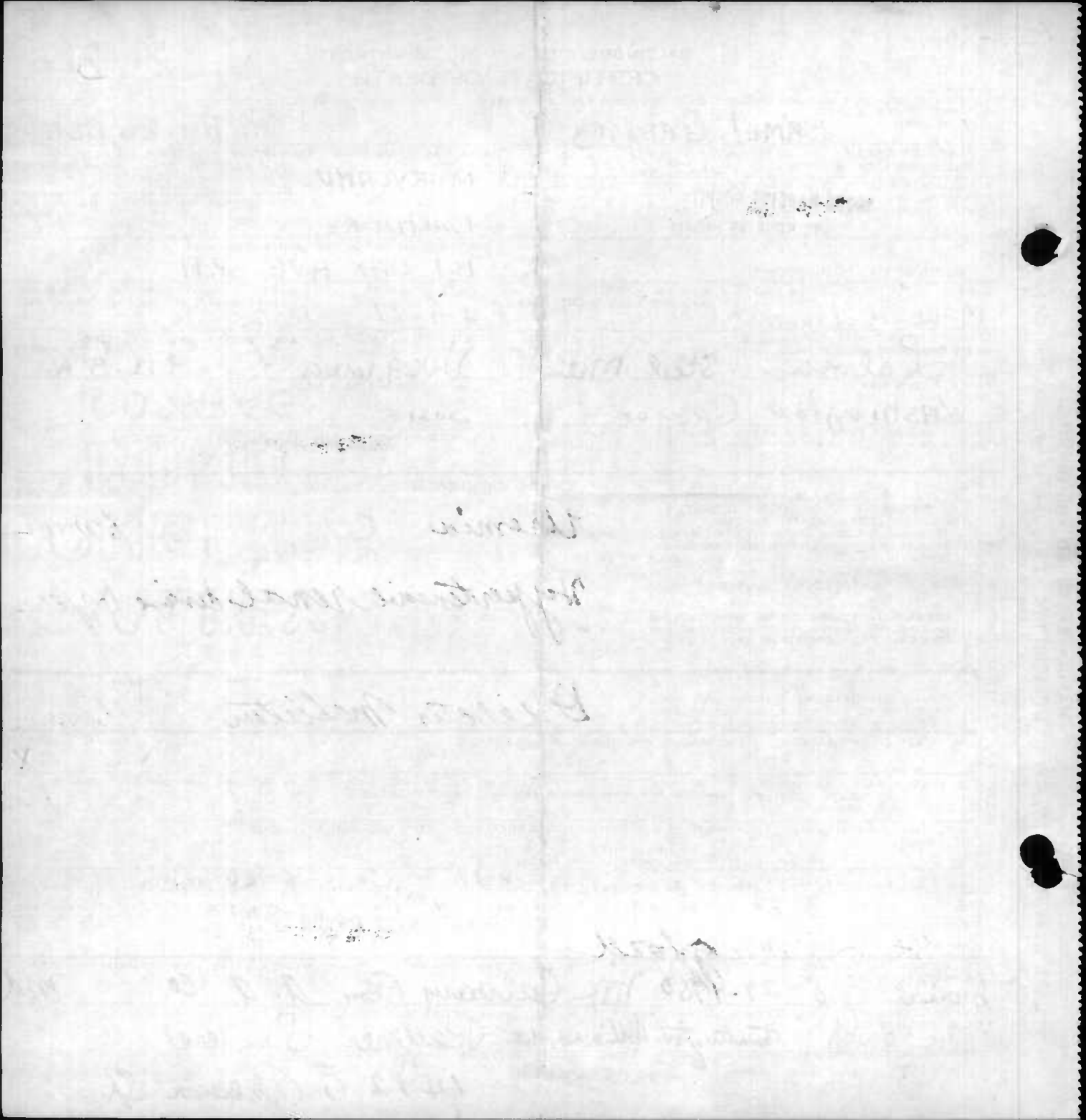
50 7456

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7456

| | | | | | |
|---|------------------------------------|---|-----------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) EMMET GREGORY | | 2. DATE OF DEATH Aug 26, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland OSLER 2. | | 4. USUAL RESIDENCE (Where deceased lived. institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION JOHN HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE | | | |
| c. Length of stay in Baltimore | | D. STREET ADDRESS (If rural, give location) 101 OAK AVE SP. 4 5300 | | | |
| 5. SEX MALE | 6. COLOR OR RACE COLORED | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 4-1-77 | 9. AGE (In years last birthday) 73 | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborn | | 10B. KIND OF BUSINESS OR INDUSTRY Steel mill | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Washington GREGORY | | 14. MOTHER'S MAIDEN NAME SUSIE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT JOHN HOPKINS HOSPITAL ADDRESS | |
| 18. 446X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chemia DUE TO | | CAUSE OF DEATH Hypertensive renal crisis by an DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus | | | |
| 19A. DATE OF OPERATION 0 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 8-17 , 19 50 , to 8-26 , 19 50 , that I last saw the deceased alive on 8-26 , 19 50 , and that death occurred at 4:30 Pm. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE W. B. Gifford | | 23B. ADDRESS JOHN HOPKINS HOSPITAL | | 23C. DATE SIGNED | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-29-1950 | | 24C. NAME OF CEMETERY OR CREMATORY Calvary Cem. A. A. Co | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | | 25. FUNERAL DIRECTOR Rayner Sanders | |
| VS 150 | | ADDRESS 1412 E. Preston St 061.0 | | | |

9703A



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-532
50 7457

50 7457

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

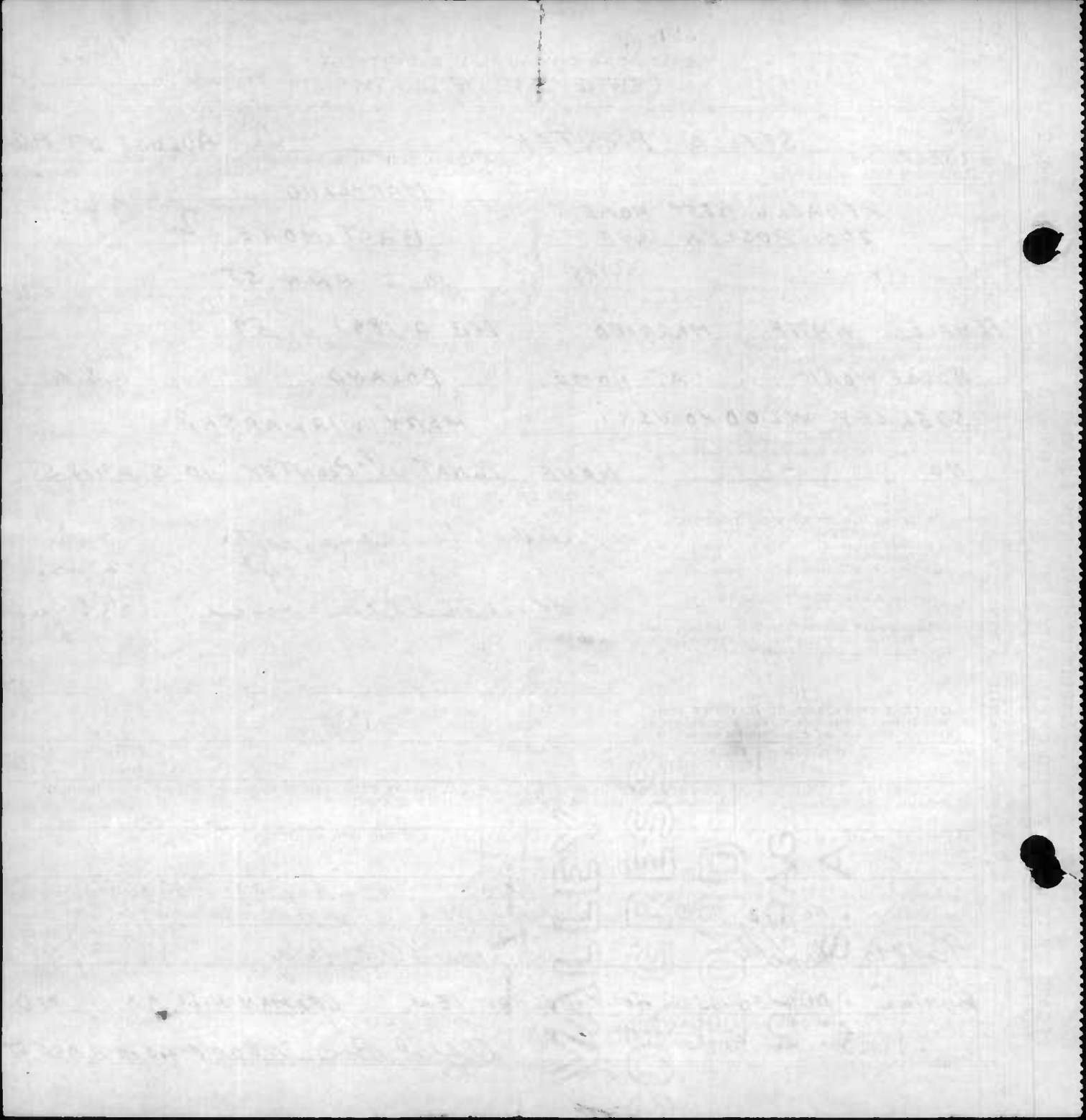
Registered No. _____

BIRTH NO. _____

| | | | |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) STELLA PIONTEK | | 2. DATE OF DEATH AUGUST 27 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY _____ | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION KENASAW REST HOME 2601 ROSLYN AVE | | C. CITY OR TOWN (If outside corporate limits, write full name and give township) BALTIMORE | |
| c. Length of stay in Baltimore 54 YRS | | D. STREET ADDRESS (If rural, give location) 10 S ANN ST | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH FEB 2 1891 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | 9. AGE (In years last birthday) 59 |
| 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME STENLEY WLODKOWSKI | | 14. MOTHER'S MAIDEN NAME MARY WIRMARSKI | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT IGNATIUS F. PIONTEK | | ADDRESS 10 S ANN ST. | |
| 18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Hemorrhage, right left DUE TO " " " " (B) Hypertension, severe DUE TO " " " " (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 yrs. 2 1/2 yrs. | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE. (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Nov. , 1948, to Aug. 27 , 1950, that I last saw the deceased alive on Aug. 26 , 1950, and that death occurred at 1 A m., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE Robert B. Wright | | 23B. ADDRESS Medical Care Bldg. | |
| 23C. DATE SIGNED Aug. 29, 1950 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE AUG 30 1950 | |
| 24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM. | | 24D. LOCATION (City, town, or county) (State) GERMAN HILL RD MD. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1950 | | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | |
| VS 150 | | FUNDAL DIRECTOR Duffel Bros. 1800 E LOMBARDO ST | |

MEDICAL CERTIFICATION

08311



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7458

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LUDWIK (LOUIS) BOREK

2. DATE
OF
DEATH

August 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2125 Eastern Avenue

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

9. AGE (In years
last birthday)

55

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Hospitals

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1st July 1917 - Feb. 1919

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Alexandra Borek 5118. Wolfe St.

18. 581.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cirrhosis of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William W. W. W.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

M.D.

MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

August 29, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 29-50

24C. NAME OF CEMETERY OR CREMATORY

Balto. National

24D. LOCATION (City, town, or county)

Balto. Co.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

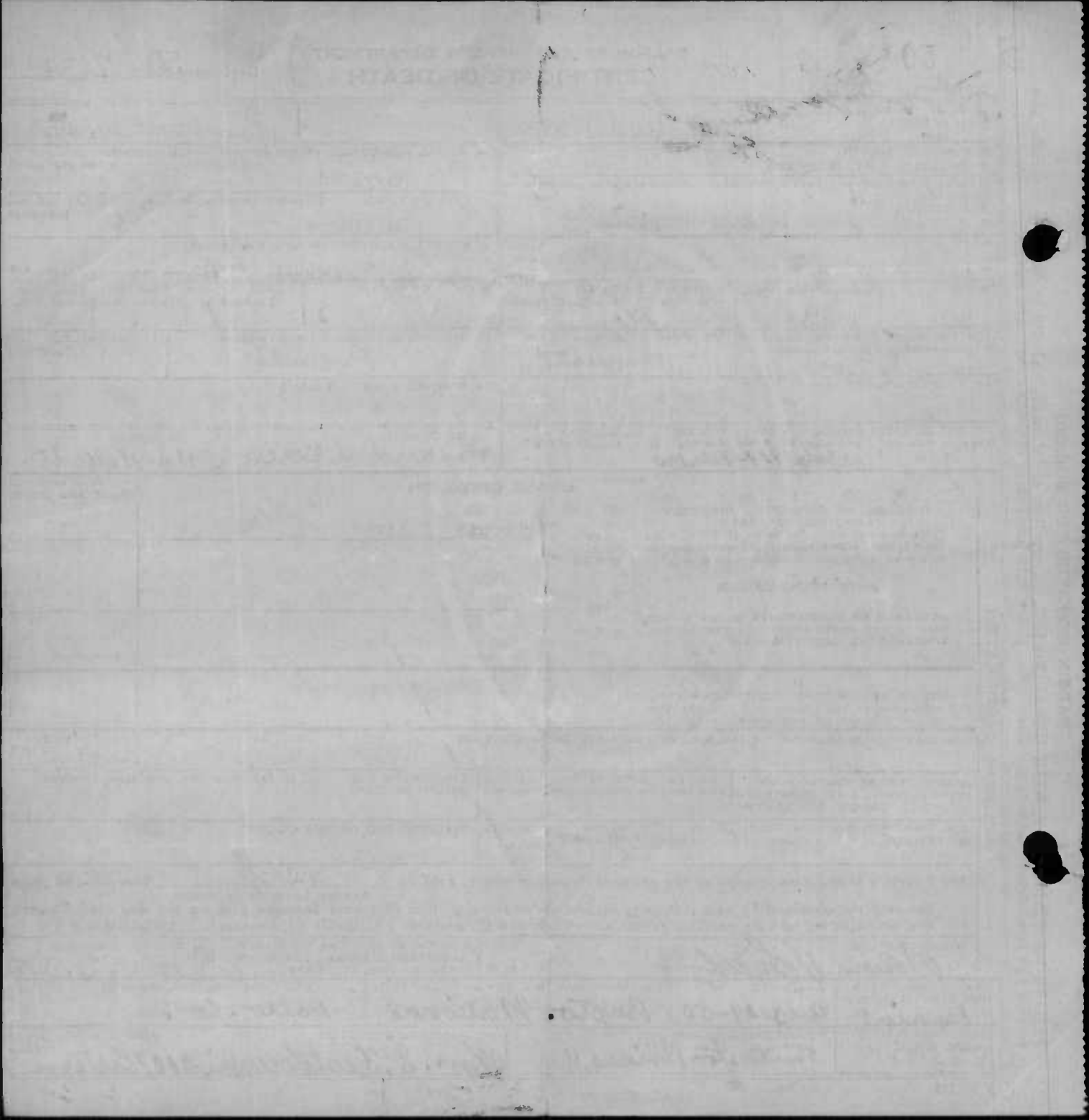
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

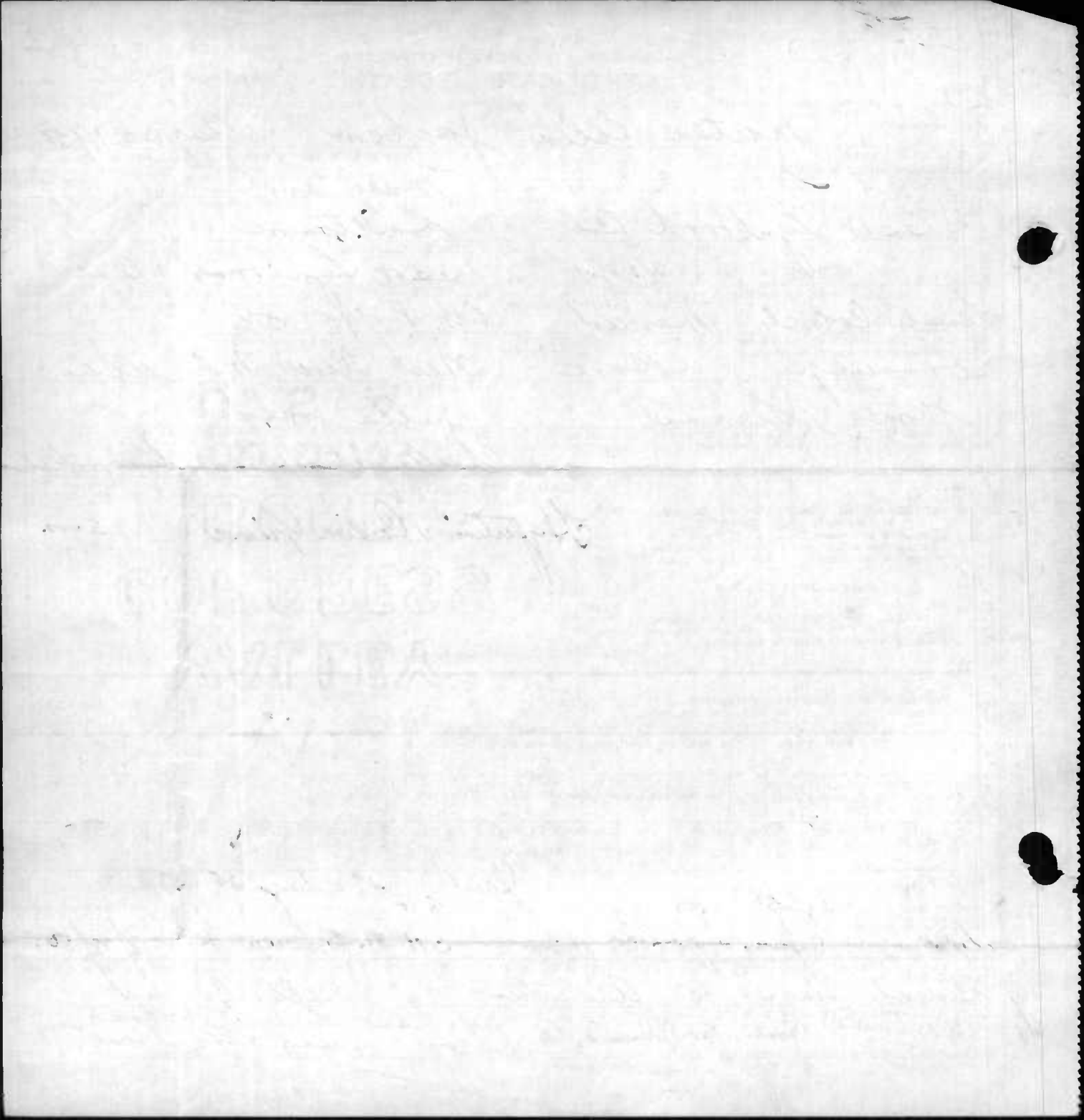
ADDRESS

Wm. S. Fialkowski 2107 Eastern Ave



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7459
Registered No.

| | | | | | |
|---|------------------------------------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Martha Ellen Jackson</i> | | 2. DATE OF DEATH <i>Aug. 25, 1950</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2208 Lynbrook Ave.</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 13-04</i> | | | |
| c. Length of stay in Baltimore <i>40 yrs.</i> | | D. STREET ADDRESS (If rural, give location) <i>2208 Lynbrook Ave.</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | | 8. DATE OF BIRTH <i>Oct. 18, 1895</i> | 9. AGE (in years last birthday) <i>56</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | 11. BIRTHPLACE (State or foreign country) <i>West River, Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>James Simms</i> | | 14. MOTHER'S MAIDEN NAME <i>Julia Jones</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Charles Jackson 2208 Lynbrook Ave.</i> | |
| 18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardiac Disease</i> | | CAUSE OF DEATH <i>Hypertensive Cardiac Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>Jan 1947</i> to <i>Aug 25, 1950</i> , that I last saw the deceased alive on <i>Aug 25, 1950</i> , and that death occurred at <i>6 P M.</i> from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Gas. Julian Jr.</i> | | 23B. ADDRESS <i>511 W. Enoch St.</i> | | 23C. DATE SIGNED <i>8/28/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Aug. 29, 1950</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Bald. Co. Md.</i> | | 24E. FUNERAL DIRECTOR <i>Halland Funeral Home</i> | | 24F. ADDRESS <i>1651 Druid Hill Ave.</i> | |
| DATE RECEIVED BY REGISTRAR <i>AUG 28 1950</i> | | REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Halland Funeral Home</i> | |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

320 50 7460

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7460

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bernard Bautz

BERNARD J. BAUTZ

2. DATE
OF
DEATH

Aug 27 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Washington D.C.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
Washington D.C.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

4550 Connecticut Ave. N.W.

5. SEX
M

6. COLOR OR RACE
W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Jan 24 1889

9. AGE (In years last birthday)

61

If Under 1 Year
Months Days

If Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Real Estate Ag.

10B. KIND OF BUSINESS OR INDUSTRY

Banking

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Michael L. Bautz

14. MOTHER'S MAIDEN NAME

Johanna Torpey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWI

16. SOCIAL SECURITY NO.
579-22-395

17. INFORMANT

ADDRESS

Mrs B.J. Bautz 4550 Connecticut Ave

18.

331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an _____ thereon and from _____ the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☐ ASSISTANT MEDICAL EXAMINER.....☒ M.D. MEDICAL INVESTIGATOR.....☒

23C. DATE SIGNED

Aug 27 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

AUG 30-1950

24C. NAME OF CEMETERY OR CREMATORY

ARLINGTON NAT CEM - VIRGINIA

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

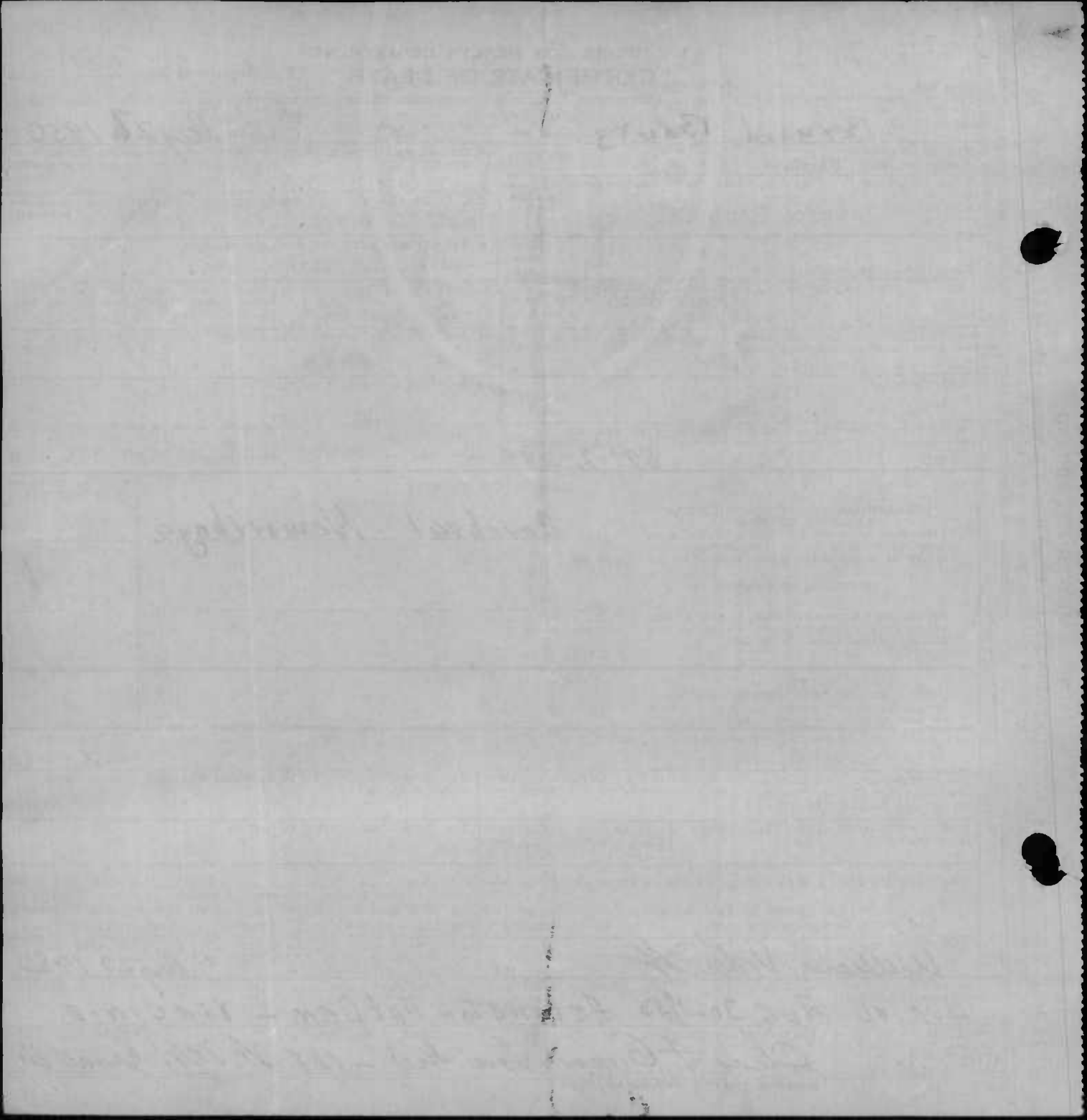
AUG 29 1950

REGISTRAR'S SIGNATURE

Chas F. Evans, And his - 118 N. Mt. Royal Dr

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John F. Kelly

2. DATE
OF
DEATH

Aug. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 522 Tunbridge Road

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

522 Tunbridge Road

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 14,

9. AGE (in years,
last birthday)

68

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR
INDUSTRY

H. K. & Co.

11. BIRTHPLACE (State or foreign country)

Baltimore Co.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Michael Kelly

14. MOTHER'S MAIDEN NAME

Catherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
216-61-8536

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

CAUSE OF DEATH

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

7 da.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

Hypertensive C-V Dis.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C)
DUE TO

Atherosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-21, 1950, to 8-27, 1950, that I last saw the
deceased alive on 8-26, 1950, and that death occurred at 11:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Chas. E. Carr, Jr.

M. D.

23B. ADDRESS

6007 York Rd.

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Rita Wiedefeld 900 E. Biddle St

STATE OF TEXAS
CERTIFICATE OF DEATH

NAME OF DECEASED
DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

OCCUPATION OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

OCCUPATION OF DECEASED

EDUCATION OF DECEASED

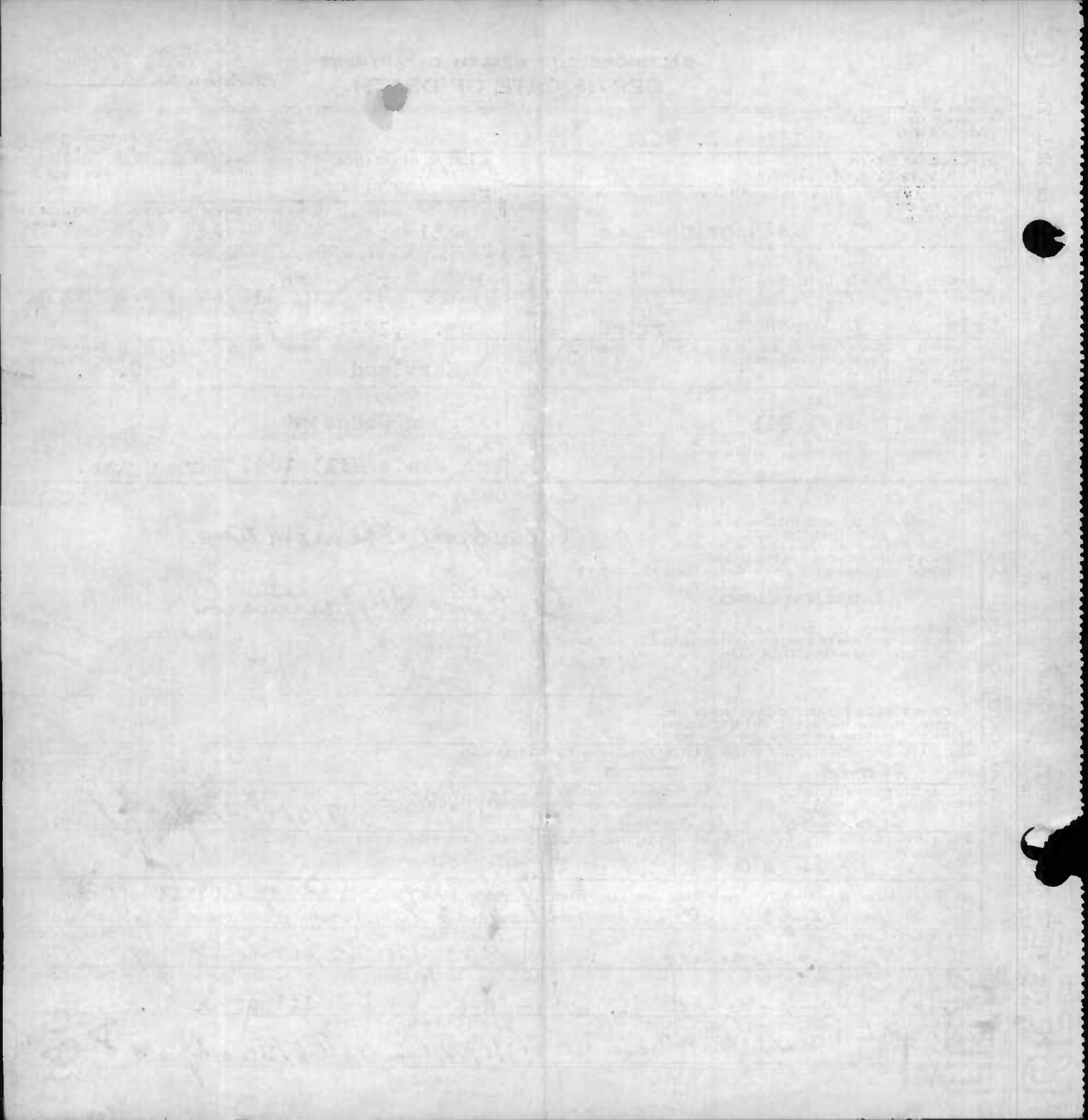
RELIGION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7462
Registered No.

| | | | | | | | | |
|---|-----------------------------|---|--|--|--|---|-----------------------------------|--|
| BIRTH NO. 400 50 7462 | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | 50 7462 Registered No. | | |
| 1. NAME OF DECEASED (Type or Print) William J. Hill | | | | | 2. DATE OF DEATH August 25, 1950 | | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2101 Coldspring Lane | | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-01 | | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | | | D. STREET ADDRESS (If rural, give location) 1043 Harlem Ave. | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Nov. 1, 1871 | 9. AGE (In years last birthday) 78 | 10. Under 1 Year Months: Days | 11. Under 24 Hours Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensioner | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Nathaniel Hill | | | | 14. MOTHER'S MAIDEN NAME Amanda Johnson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs Mamie Hill 1043 Harlem Ave. | | | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cerebral Hypertension DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO II | | | | | CAUSE OF DEATH Cerebral Hemorrhage Cerebral Hypertension DUE TO DUE TO DUE TO | | | |
| 19A. DATE OF OPERATION None | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) None | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2101 Coldspring Lane | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 8-25-50 | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I hereby certify that I attended the deceased from Jan. 1949, 19, to Aug 24, 1950 that I last saw the deceased alive on Aug 24, 1950, and that death occurred at 6 P. M., from the causes and on the date stated above. | | | | | | | | |
| 23A. SIGNATURE C. M. Lawrence | | | | 23B. ADDRESS M. D. 1033 W. Lawrence St | | 23C. DATE SIGNED 8/28/50 | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-29-50 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1950 | | REGISTRAR'S SIGNATURE Christington Williams, M.D. | | FUNERAL DIRECTOR Mrs Lawrence C. Hemphill | | ADDRESS 578 W. Biddle St. | | |
| VS 150 | | | | | | | | |



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7463
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Jennie Young

2. DATE
OF
DEATH

August 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1124 Riggs Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1124 Riggs Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Widow

8. DATE OF BIRTH

Aug. 10, 1887

9. AGE (In years last birthday)

63

10 Under 1 Year 11 Under 24 Hours
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Moses Carter

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. William Carter 1124 Riggs Ave.

18. **4221**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **CARDIO VASCULAR DISEASE**

5 YRS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) **PULMONARY OEDEMA**

3 DAYS

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Aug 19, 1950**, to **Aug 26, 1950**, that I last saw the deceased alive on **Aug 26, 1950**, and that death occurred at **7:30 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

William Frey

23B. ADDRESS

1938 Penna Ave

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-30-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

AUG 29 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Mr. Lawrence G. Henderson

ADDRESS

578 W. Biddle St.

VS 150

093.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[Faint, mostly illegible text covering the body of the document, appearing to be a memorandum or report.]

465 50 7464

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7464

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HAROLD EDGAR CLEARMAN, Sr.

2. DATE
OF
DEATH

8-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

38 University Hospital

Yrs.
Mos.
Days

C. CITY OR TOWN

Md.

Essex, Md. rural - Baltimore

D. STREET ADDRESS (If rural, give location)

900 Wilson Point Rd.

53-00

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 5, 1876

9. AGE (In years
last birthday)

74

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Navy Inspector

10B. KIND OF BUSINESS OR
INDUSTRY

Airplane industry

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John ? Clearman

14. MOTHER'S MAIDEN NAME

Nettie Wallis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

yes

(If yes, give war or dates of service)

Apanish Amer.

16. SOCIAL
SECURITY NO.

none

17. INFORMANT 900 Wilson Pt. Rd. Essex
Mrs. Helen G. Clearman

18.

610X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Hemorrhage from Bladder

INTERVAL BETWEEN
ONSET AND DEATH

15Q

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Retrophic prostatectomy

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Senility

19A. DATE OF OPERATION

8-8-50

19B. MAJOR FINDINGS OF OPERATION

Prostatic Hypertrophy

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-450, 1950, to 8-27, 1950, that I last saw the
deceased alive on 8-26, 1950, and that death occurred at 12:30 m., from the causes and on the date stated above.

23A. SIGNATURE

E. J. Braddish

M. D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

8-28

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale Cem.

24D. LOCATION (City, town, or county)

Montclair, N.J.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

AUG 29 1950

REGISTRAR'S SIGNATURE

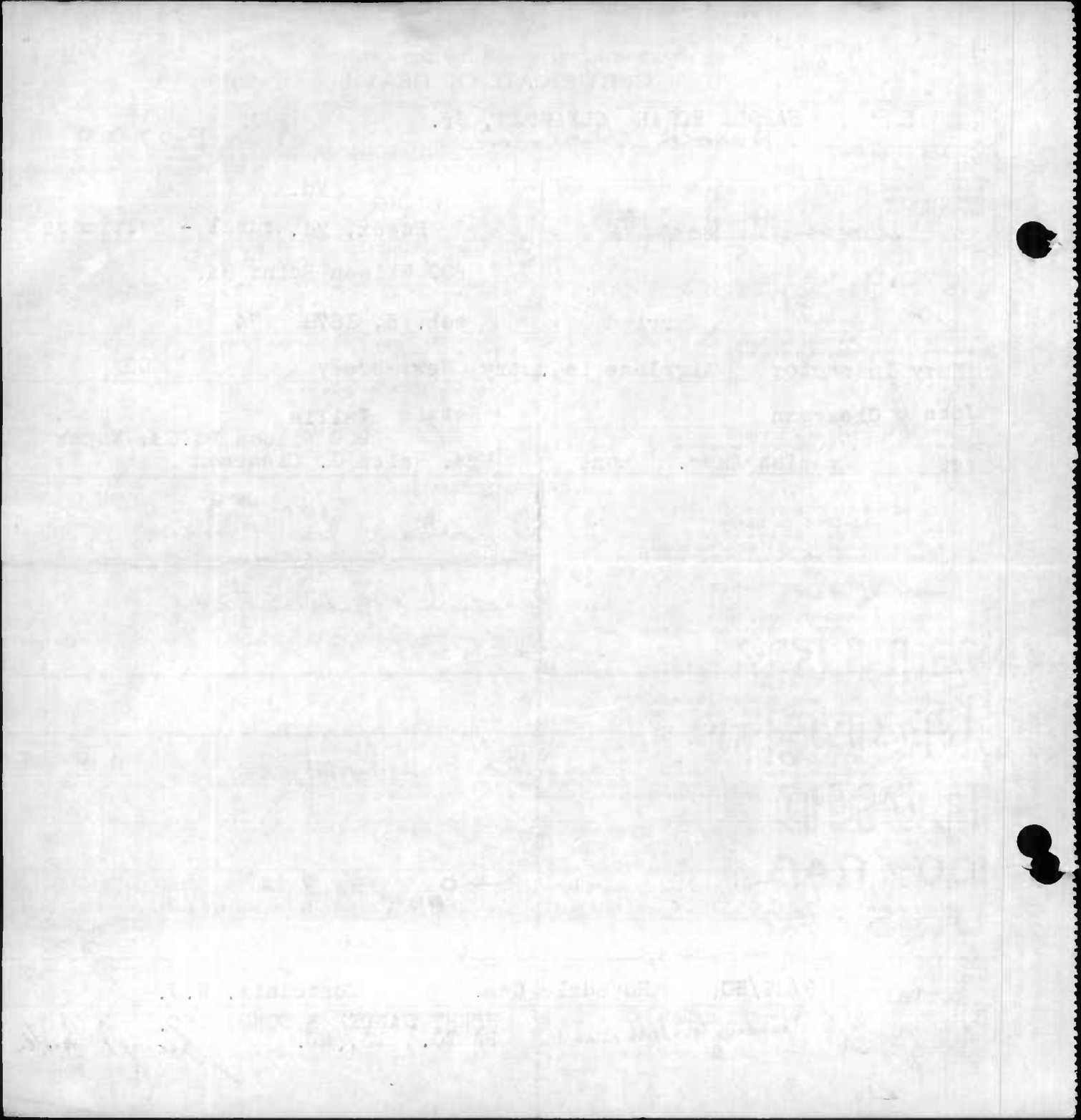
Huntington Williams, M.D.

FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.
BALTO., 13, MD.

ADDRESS

George J. Sander



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N-240
50 7465

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 7465
Registered No.

| | | | | | |
|---|----------------------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>John Nissell</u> | | 2. DATE OF DEATH <u>August 28, 1950</u> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <u>626 Wyanoke Ave</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION | | C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) <u>Baltimore</u> | | | |
| C. Length of stay in Baltimore <u>75</u> | | D. STREET ADDRESS (If rural, give location) <u>626 Wyanoke Ave</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Aug. 23, 1875</u> | 9. AGE (In years last birthday) <u>75</u> | 10. Under 1 Year Months: Days: Hours: Min. <u>5</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper (Bank)</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>John Adam Nissell</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Reitz</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>626 Wyanoke Avenue</u> <u>Miss Christine Nissell</u> | |

| | | |
|--|---|---|
| 18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH (A) <u>Cardio sclerosis</u> DUE TO (B) <u>Arterio sclerosis</u> DUE TO (C) <u>Advanced age, genit. debility</u> | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>10 yrs.</u> |
|--|---|---|

| | | | | | |
|---|---|--|--|---|--|
| 19A. DATE OF OPERATION <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 1949</u> to <u>Aug. 28, 1950</u> , that I last saw the deceased alive on <u>Aug. 28, 1950</u> , and that death occurred at <u>11:30</u> a.m., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <u>Paul J. Buzzott</u> | | 23B. ADDRESS <u>3812 Greenmount Ave</u> | | 23C. DATE SIGNED <u>8/29/50</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 24B. DATE <u>9/1/50</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>AUG 29 1950</u> | | REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u> | | 25. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> <u>BALTO. 13, Md.</u> | |

VS 150

093.4

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

Registered No. _____

| | | | | | |
|-------------------------|--|---|--|---------|--|
| 2 DATE OF DEATH | | 3 USUAL RESIDENCE (Write on card if death occurred elsewhere) | | 4 STATE | |
| 5 CITY OF TOWN | | 6 STREET ADDRESS (If rural, give location) | | 7 RACE | |
| 8 DATE OF BIRTH | | 9 PLACE OF BIRTH (State and County) | | 10 SEX | |
| 11 MOTHER'S MAIDEN NAME | | 12 CITIES OF WHAT COUNTRY | | 13 | |
| 14 | | 15 | | 16 | |
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| 86 | | 87 | | 88 | |
| 89 | | 90 | | 91 | |
| 92 | | 93 | | 94 | |
| 95 | | 96 | | 97 | |
| 98 | | 99 | | 100 | |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

5-524
50 7466

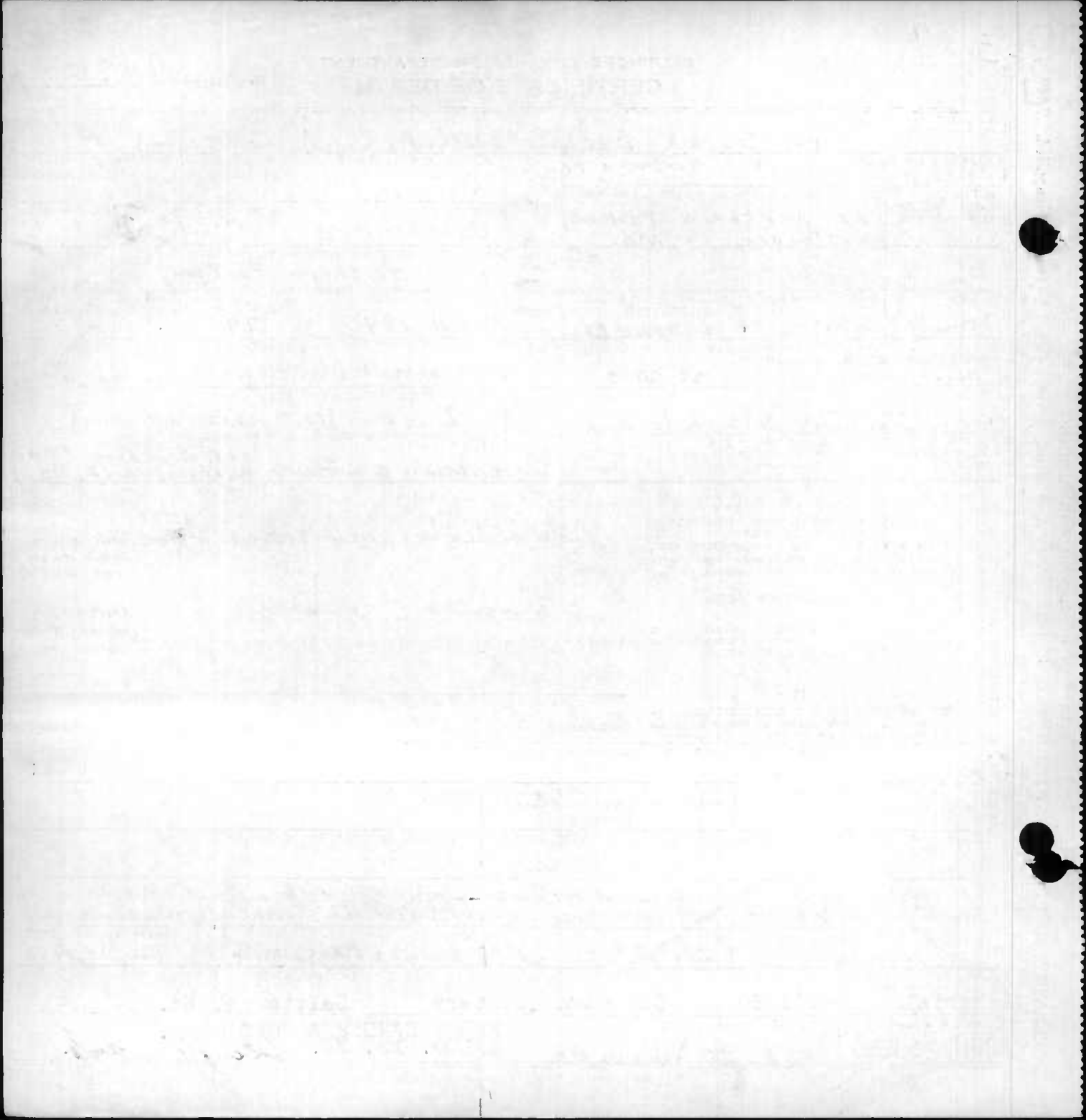
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7466

BIRTH NO.

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Mrs. Sarah Evelyn SINCLAIR</i> | | | 2. DATE OF DEATH <i>Aug 28, 1950</i> | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1781 Northern Pkwy</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1781 Northern Parkway Baltimore 12, Md.</i> | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>27-38</i> | | |
| c. Length of stay in Baltimore <i>40</i> Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) <i>1781 Northern Parkway</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i> | 8. DATE OF BIRTH <i>Oct 11, 1870</i> | 9. AGE (In years last birthday) <i>79</i> | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | 11. BIRTHPLACE (State or foreign country) <i>Northumberland Co., Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>United States</i> |
| 13. FATHER'S NAME <i>Mr. [first name] Shackelford</i> | | | 14. MOTHER'S MAIDEN NAME <i>Lucy [last name unknown]</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. — | 17. INFORMANT ADDRESS <i>Mr. Leland B. Sinclair 1781 Northern Pkwy Baltimore 12, Md.</i> | | |

| | | | | | |
|--|--|--|----------------------------------|---|--|
| 18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Cardiovascular Disease</i> (A) DUE TO <i>Unknown (more than one week)</i> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerosis, General</i> (B) DUE TO <i>Unknown (more than one week)</i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Massive Bilateral Pleural Effusions</i> (C) DUE TO <i>1 week</i> | | | | | |
| 19A. DATE OF OPERATION <i>None</i> | | 19B. MAJOR FINDINGS OF OPERATION — | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I hereby certify that I attended the deceased from <i>Aug 22, 1950</i> , to <i>Aug 28, 1950</i> , that I last saw the deceased alive on <i>Aug 28, 1950</i> , and that death occurred at <i>10:15 P.m.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Charles C. Shaw MD</i> | | 23B. ADDRESS <i>M. D. 1837 Northern Pkwy, Balto-12</i> | | 23C. DATE SIGNED <i>Aug 28, 1950</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>8/31/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | | | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 29 1950</i> | | REGISTRAR'S SIGNATURE <i>Wilmington Williams, MD</i> | | GENERAL FUNERAL DIRECTOR <i>HENRY SANDER & SONS, INC. BALTO. 13, MD. [Signature]</i> | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

VIRGINIA NEIVA ROCKWELL

2. DATE
OF
DEATH

Aug 26, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1732 N. Calvert Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1732 N. Calvert Street

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 12, 1923

9. AGE (In years
last birthday)

26

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of worklog life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Digman

14. MOTHER'S MAIDEN NAME

Blanche Post

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT 1732 N. Calvert Street
Mr. Donald L. Rockwell

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Coronary Heart Failure

3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Chronic Valv. Heart Dis

20 yrs

(C)

DUE TO

Rheumatic Endocarditis

20 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1, 1950 to 8/26, 1950 that I last saw the
deceased alive on 8/26, 1950, and that death occurred at 11:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

8/29/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore national cemetery Balto. Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S ADDRESS

HENRY SANDER & SONS, INC.
BALTO. 13, MD.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-7468

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Varella

2. DATE
OF
DEATH

August 26 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 954 Forrest St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Maryland Penitentiary

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

902 Eastern Ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 14 1906

9. AGE (In years
last birthday)

44

10 Under 1 Year
Months: Days

5 12

11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Antonio Varella

14. MOTHER'S MAIDEN NAME

Rose Poggi

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

H. W. Holljes, M. D. -954 Forrest St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Ventricular Fibrillation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Acute coronary insufficiency

DUE TO Aortic & mitral insufficiency

(C) Probable rheumatic heart disease

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9 1950, to Aug. 26 1950, that I last saw the
deceased alive on May 15 1950, and that death occurred at 10:10 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial

Aug. 30/50

Holy Redeemer Cemetery

4430 Belair Rd. Balt. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

8-29-50

William Williams, M.D.

Frank Della Noce-

322 S. High St.

APR 1962

APR 1962

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APR 1962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Samed Johnson

2. DATE
OF
DEATH

Aug 27 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF

(If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write full name and give township)

Baltimore 16002

D. STREET ADDRESS (If rural, give location)

1426 Mosher St

C. Length of stay in Baltimore

LIFE

5. SEX

Male

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

6/10/1925

9. AGE (In years

last birthday)

25

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Johnson

14. MOTHER'S MAIDEN NAME

Cordilia Moses

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Cordilia Johnson 1426 Mosher St

18. E92X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab wound of Heart

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2011 E. Biddle Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 26, 1950 10:00 P.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Sharp instrument

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

William V. [Signature]

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Aug 27, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/31/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Zion Cemetery

24D. LOCATION (City, town, or county)

Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

ADDRESS

Joseph A. Hively 661 W. Barre

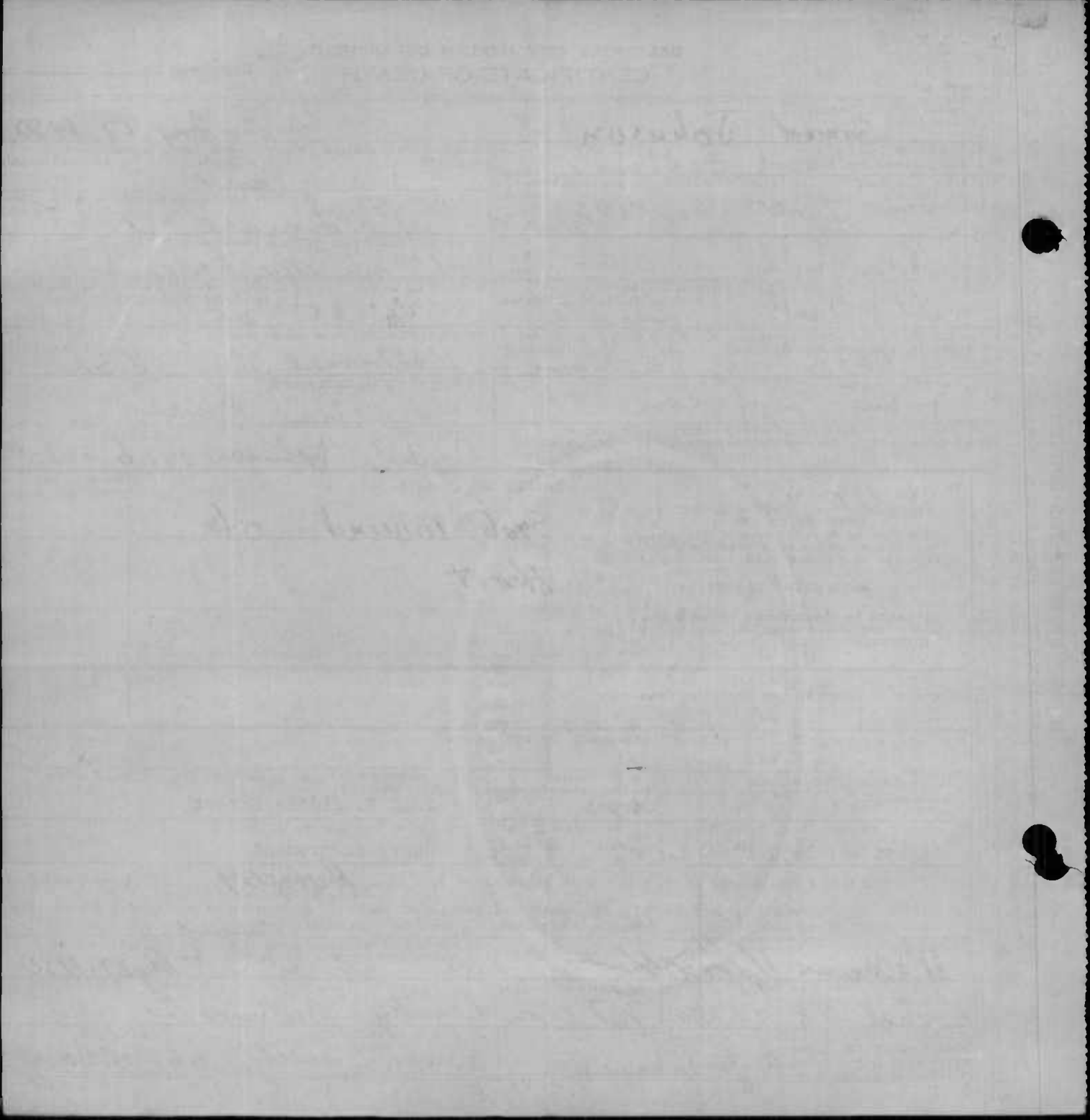
VS 151

8612

75464

167.0

167.0



S-453
50 7470BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7470

| | | | | | |
|--|----------------------------------|---|---|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Joseph C. Slunt | | 2. DATE OF DEATH 8-28-50 | |
| 3. PLACE OF DEATH A. Baltimore City, Maryland BALTIMORE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 44 | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 3503 Pulaski Highway | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 26 | | | |
| c. Length of stay in Baltimore Yrs. 66 Mos. Days | | D. STREET ADDRESS (If rural, give location) 3503 Pulaski Highway | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH May 30, 1884 | 9. AGE (In years last birthday) 66 | 10. Under 1 Year Months: Days 2 28 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Mechanist | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Slunt | | 14. MOTHER'S MAIDEN NAME Henrietta Dietrich | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Leo C. Slunt 1812 Thomas Ave | |
| 18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis DUE TO This is probably the cardiac DUE TO vascular and chronic DUE TO ? INTERVAL BETWEEN ONSET AND DEATH 6 weeks | | CAUSE OF DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 14, 1950 to August 1, 1950 , that I last saw the deceased alive on August 26, 1950 , and that death occurred at 8:45 p.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Charles E. Schaub | | 23B. ADDRESS 1939 Mc Elroy St | | 23C. DATE SIGNED 8/29/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-31-1950 | | 24C. NAME OF CEMETERY OR CREMATORY Cathlam Cemetery Baltimore, Md | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | 25. FUNERAL DIRECTOR Charles W. Conklin | | ADDRESS 924 E. Eager St. | |
| DATE RECEIVED BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE Wilmington Williams, Md | | | |

VS 150

5443L

131.1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr Albert E. Silewski
The Elders & Potomac Ave

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

| | | | |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) SOPHIE MARIE ROTH | | 2. DATE OF DEATH Aug. 27, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 2836 Herkimer St | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY _____ | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION _____ | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| c. Length of stay in Baltimore Life. Yrs. _____ Mos. _____ Days _____ | | D. STREET ADDRESS (If rural, give location) 2836 Herkimer St. 25-52 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug. 19, 1895 9. AGE (In years last birthday) 55 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10B. KIND OF BUSINESS OR INDUSTRY At home | 11. BIRTHPLACE (State or foreign country) Baltimore Md. |
| 13. FATHER'S NAME John Creamer | | 14. MOTHER'S MAIDEN NAME Katherine Kramer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| | | 17. INFORMANT ADDRESS Harry Roth 2836 Herkimer St. | |

| | | | |
|---|---|-----------------------|---|
| MEDICAL CERTIFICATION | 18. 331X | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Cerebral Hemorrhage | | 3 1/2 hours |
| | DUE TO (B) Cerebral Arteriosclerosis | | unknown |
| | DUE TO (C) Diabetes Mellitus | | unknown |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| | | | | | |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION None | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) NO | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 8 , 19 50 , to August 27 , 19 50 , that I last saw the deceased alive on August 27 , 19 50 , and that death occurred at 11:45 A. M. from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Richard S Hahn | | 23B. ADDRESS 1823 Park Ave (17) | | 23C. DATE SIGNED 8/28/50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 30, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1950 | | REGISTRAR'S SIGNATURE Thurston Williams, M.D. | | 25. FUNERAL DIRECTOR ADDRESS Mr. Mrs. John R. Guehl, Box 5311 Edmondson Ave | |

VS 150

06110

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rt 300
50 7471

50 7471

STATE OF NEW YORK
DEPARTMENT OF HEALTH

100

100

WALLEY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. SAWYER

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 7472

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY Shaw

2. DATE
OF
DEATH

Aug. 28-1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

6028 010 HARTFORD RD.

Yrs.
Mos.
Days

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

c. CITY OR TOWN (If outside corporate limits, write full name of township)

BALTIMORE

d. STREET ADDRESS (If rural, give location)

3304 Rosekemp Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

MAR. 13-1874

9. AGE (In years - last birthday)

76

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Timekeeper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry Shaw

14. MOTHER'S MAIDEN NAME

Grace Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-07-6513

17. INFORMANT

ADDRESS Evergreen

MRS. Joseph Reitemeyer - 3104

18. 260X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart Disease

5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis

10 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Diabetes Mellitus

Unknown

Psychosis due to Arteriosclerosis

1 year

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1950, to Aug 28, 1950, that I last saw the deceased alive on Aug 26, 1950, and that death occurred at 12:10 P. M., from the causes and on the date stated above.

23A. SIGNATURE

G. Sawyer

23B. ADDRESS

4808 Hartford Rd.

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/31/50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 29 1950

REGISTRAR'S SIGNATURE

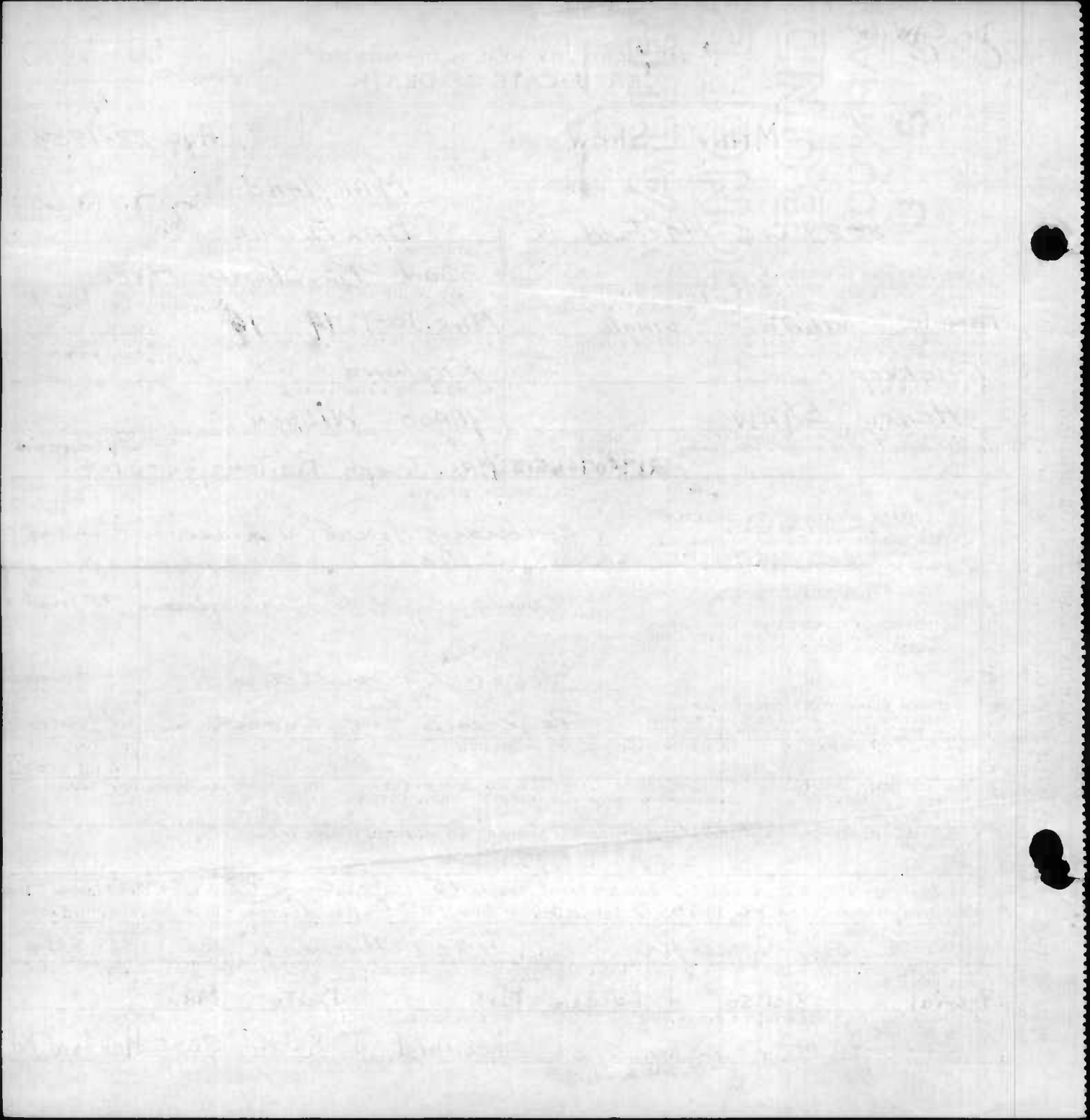
Huntington Williams, MD

25. FUNERAL DIRECTOR

Leonard J. Ruck

ADDRESS

5305 Hartford Rd



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7473

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE E. ANDERSON

2. DATE
OF
DEATH

August 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

c. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

1813 E. Eager Street

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

7/1/86

9. AGE (In years
last birthday)

54 64

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR
INDUSTRY

Maritime Service

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George E. Anderson

14. MOTHER'S MAIDEN NAME

Hannah Ayers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI 1917

16. SOCIAL
SECURITY NO.

086-12-1376

17. INFORMANT

ADDRESS

Walter Anderson 1813 E. Eager St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular

disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Durechen M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

August 28, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

8/31/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Balto., Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Charles L. Law - 802 Madison Ave.

AUG 29 1950

75491

093.4

OFFICE OF THE SECRETARY OF THE ARMY

8/31/50
[Illegible handwritten text]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7474

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Calvin Morgan

2. DATE
OF
DEATH

8/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Md.

Baltimore City

D. STREET ADDRESS (If rural, give location)

301 Sollers Point Rd. 53-00

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

2-3-07

9. AGE (In years last birthday)

43

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR INDUSTRY

Dundalk Housing Assn. Appomattox, Va.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Morgan

14. MOTHER'S MAIDEN NAME

Ella Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mary Scruggs - 113 Willow Ct. Baltimore

18. 592X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Uremia

2 days

DUE TO

Chronic glomerulonephritis

ANTECEDENT CAUSES

(B)

Cardiac failure

DUE TO

hypertensive heart disease

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8/26/50 to 8/28, 1950, that I last saw the deceased alive on 8/28, 1950, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Aristomere Nicolas

M. D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

8/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-2-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Zion

24D. LOCATION (City, town, or county)

Appomattox, Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Charles R. Law - 802 Madison Ave.

301 College Lane
St. Louis, Mo.

2-3-07

Heir Separated

During his absence from the service

Ellis Johnson

William Johnson

May 20, 1907 - 1910

40

7-2-20

Agreement

John A. Johnson

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7475

Registered No. _____

50 7475

BIRTH NO.

| | | | |
|--|---|---|---|
| 1. NAME OF DECEASED (Type or Print) <i>Edward Coleman</i> | | 2. DATE OF DEATH <i>Aug. 26, 1950</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i> | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1319 Myrtle Ave.</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> | |
| c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ | | D. STREET ADDRESS (If rural, give location) <i>1319 Myrtle Ave.</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Col.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i> | 8. DATE OF BIRTH <i>Jan. 29, 1899</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i> | 10B. KIND OF BUSINESS OR INDUSTRY <i>Factory</i> | 11. BIRTHPLACE (State or foreign country) <i>Balto.</i> | 9. AGE (In years, last birthday) <i>51</i> |
| 13. FATHER'S NAME <i>William Coleman</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No.</i> | | 16. SOCIAL SECURITY NO. _____ | |
| 14. MOTHER'S MAIDEN NAME <i>Mary E Collins</i> | | 17. INFORMANT <i>Frank E. Coleman</i> | |
| 18. <i>592 X</i> | | ADDRESS <i>1319 Myrtle Ave.</i> | |

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cardiac De compensation*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 mpr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Chronic Nephritis*

DUE TO

240

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) _____

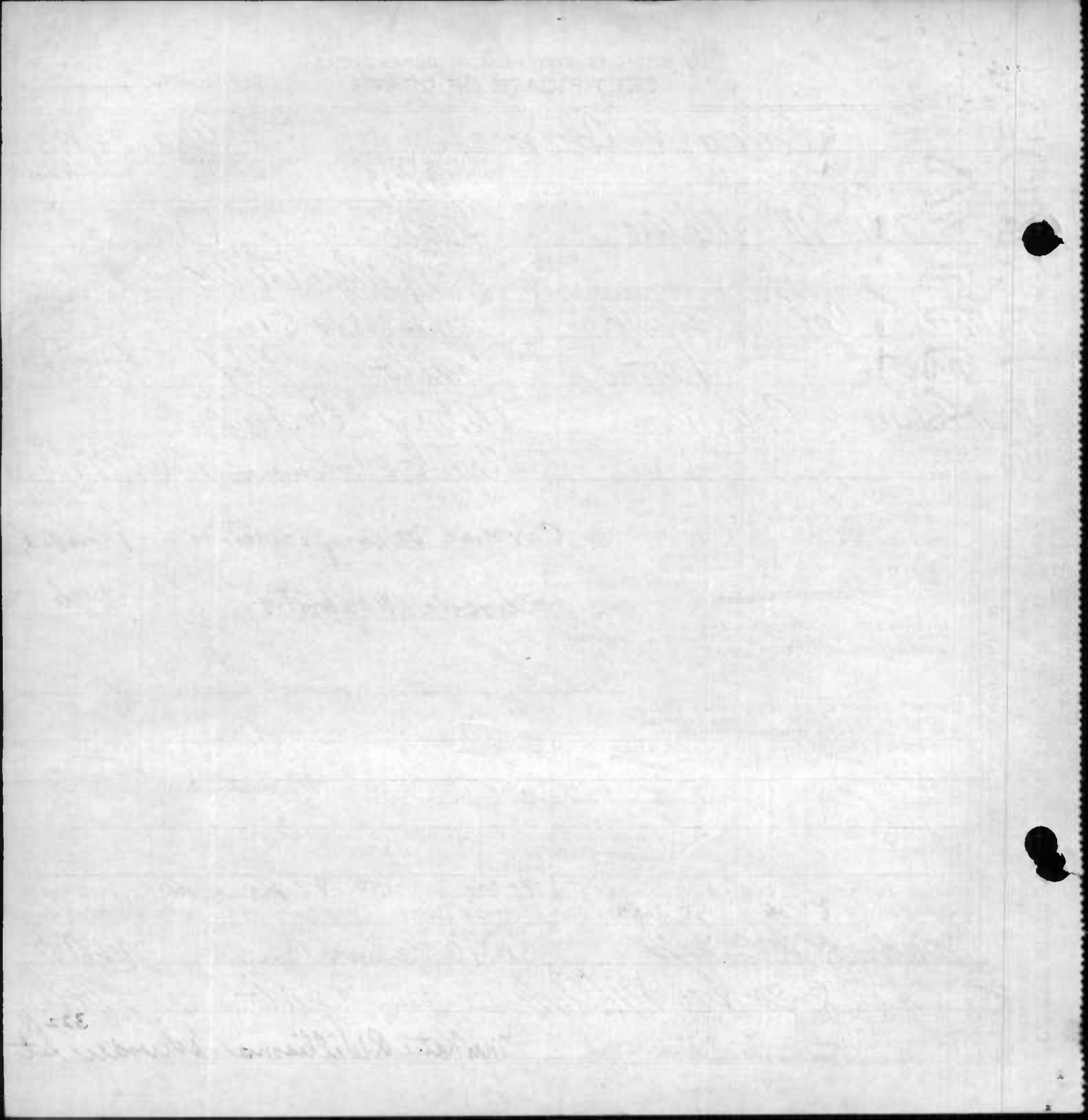
MEDICAL CERTIFICATION

| | | | | | |
|--|---|--|---------------------------------------|--|--|
| 19A. DATE OF OPERATION <i>8-30-1950</i> | | 19B. MAJOR FINDINGS OF OPERATION <i>0.</i> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>7-26</i> , 19 <i>50</i> , to <i>8-26</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>8-26</i> , 19 <i>50</i> , and that death occurred at <i>1:00 p.m.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>Dr. Martin L. Lippis</i> | | 23B. ADDRESS M. D. <i>1543 Remond Ave.</i> | | 23C. DATE SIGNED <i>8/28/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE <i>8-30-1950</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i> | 24D. LOCATION (City, town, or county) | (State) <i>Balto.</i> | |
| DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 29 1950</i> | | REGISTRAR'S SIGNATURE <i>Wm. H. Williams, M.D.</i> | | 25. FUNERAL DIRECTOR <i>Mrs. Katie R. Williams</i> | |
| | | | | ADDRESS <i>Schweizer St.</i> | |

VS 150

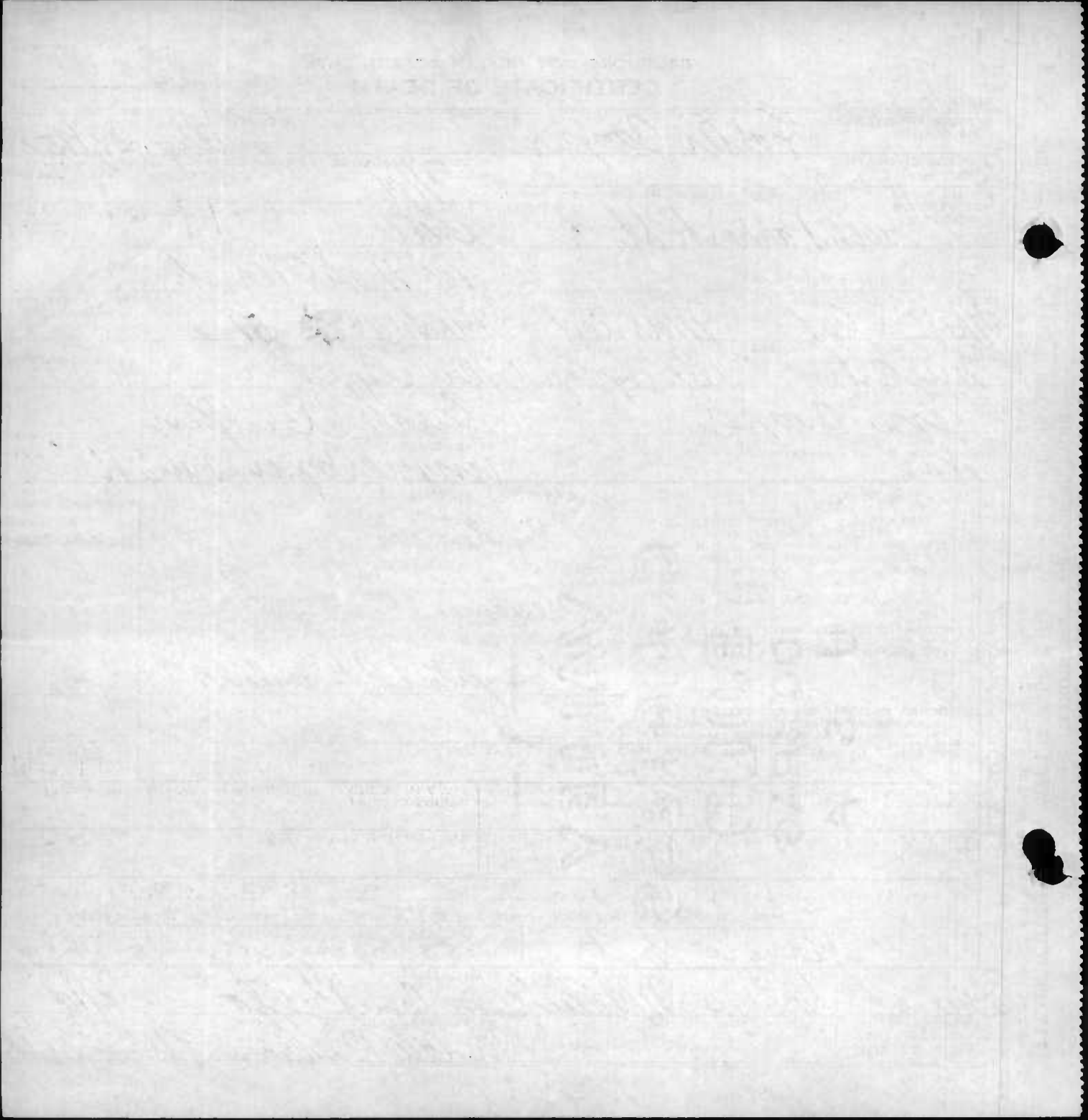
7804Y

131.2



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7476
Registered No.

| | | | | | |
|--|--------------------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Foster Cooper</i> | | 2. DATE OF DEATH <i>Aug. 29, 1950</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>19-01</i> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>400 N. Parrish St.</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> | | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) <i>400 N. Parrish St.</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Cot</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>March 1, 1893</i> | 9. AGE (In years, last birthday) <i>57</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truckster</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i> | | 11. BIRTHPLACE (State & foreign country) <i>Mississippi</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Levi Cooper</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah Bulfin</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT, ADDRESS <i>Annie Cooper Parrish 400 N.</i> | |
| 18. <i>293X</i> <i>Hypertension</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (A) <i>Hypotension</i> DUE TO (B) <i>Cerebrin</i> DUE TO (C) <i>Congestive Ht. Failure</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i> | |
| 19A. DATE OF OPERATION <i>none</i> | | 19B. MAJOR FINDINGS OF OPERATION <i>none</i> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>8-8</i> , 1950, to <i>8-22</i> , 1950, that I last saw the deceased alive on <i>8-22</i> , 1950, and that death occurred at <i>6:30</i> A.M., from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>George A. Zheat</i> | | 23B. ADDRESS <i>753 George St.</i> | | 23C. DATE SIGNED <i>8-29-50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Sept. 1, 1950</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>W. T. Culburn Cem. Balto.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>MD</i> | | 24E. REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i> | | 24F. FUNERAL DIRECTOR <i>Mr. Kelli R. Williams</i> | |
| 24G. ADDRESS <i>322</i> | | DATE RECEIVED BY LOCAL REGISTRAR <i>AUG 29 1950</i> | | | |



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7477

BIRTH NO. 235

1. NAME OF DECEASED
(Type or Print)

MARY M. McDONOUGH

2. DATE
OF
DEATH

August 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

620 S. Kenwood Avenue

C. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 9th. 1925

9. AGE (In years last birthday)

25

10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Operator

10B. KIND OF BUSINESS OR INDUSTRY

Telephone Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William L. McDonough

14. MOTHER'S MAIDEN NAME

Margaret E. Lepper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Margaret E. McDonough

ADDRESS

620 S. Kenwood Ave.

18. EPIC. I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of skull

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pulaski Highway near Erdman Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

August 28, 1950 1:20 A.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into parked trailer-truck

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Durlacher

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

August 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-31-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore

Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 29 1950

REGISTRAR'S SIGNATURE

William L. Williams, Jr.

25. FUNERAL DIRECTOR

John Q. Moran

ADDRESS

3000 E. Baltimore St

VS 151

N-803.2

3705A

170.3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

STATE OF NEW YORK

| | | | |
|-----------------------|--|------------------------------|--|
| Name of Deceased | | Date of Death | |
| Sex | | Age | |
| Place of Birth | | Usual Residence | |
| Cause of Death | | Manner of Death | |
| Physician's Signature | | Medical Examiner's Signature | |
| Date of Certificate | | Place of Death | |

PLEASE WRITE PRECISELY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Hoffmeister

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

50 7478

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)*Walter J. Hoffmeister*2. DATE
OF
DEATH*8/22/50*3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE _____ B. COUNTY _____B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

C. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

509 Millington Lane

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 17, 1902

9. AGE (In years last birthday)

48

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NEVER WORKED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Hoffmeister

14. MOTHER'S MAIDEN NAME

Margaret Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Lane**Anna Hoffmeister 509 Millington*

18.

4221

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Antenatal C. U. Disease*DUE TO *Post Infectious*(B) *Encephalitis Lethargica*

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

P. L. Lubinski

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

8/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/30/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem

24D. LOCATION (City, town, or county)

Baltimore

(State)

MD.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

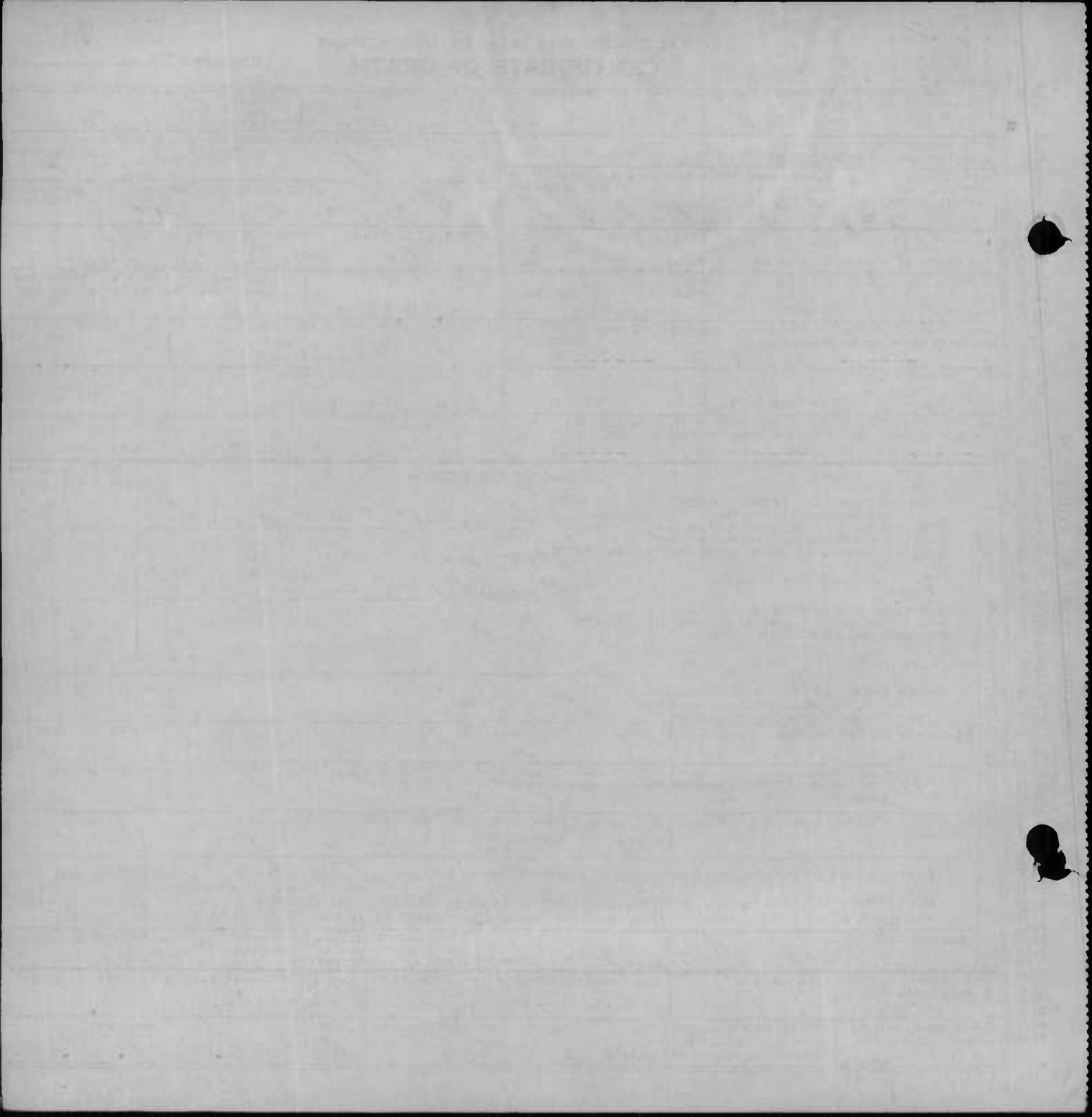
25. FUNERAL DIRECTOR

ADDRESS

John A. Moran 3000 E. Balto. St.

VS 151

093-4 ✓



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 7479

BIRTH NO. 50 7479

| | | | |
|---|------------------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) LOUISE JIGGETTS | | 2. DATE OF DEATH August 27, 1950 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) Franklin Square Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) 1635 W. Lexington Street | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Dec. 26, 1869 |
| 9. AGE (In years last birthday) 80 | | 10. UNDER 1 Year Months: Days: Hours: Min. | 11. BIRTHPLACE (State or foreign country) Tarboro, North Carolina |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME John Hudson | |
| 14. MOTHER'S MAIDEN NAME Winnie Scholfield | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS James Jiggetts, 1635 Lexington Street | |

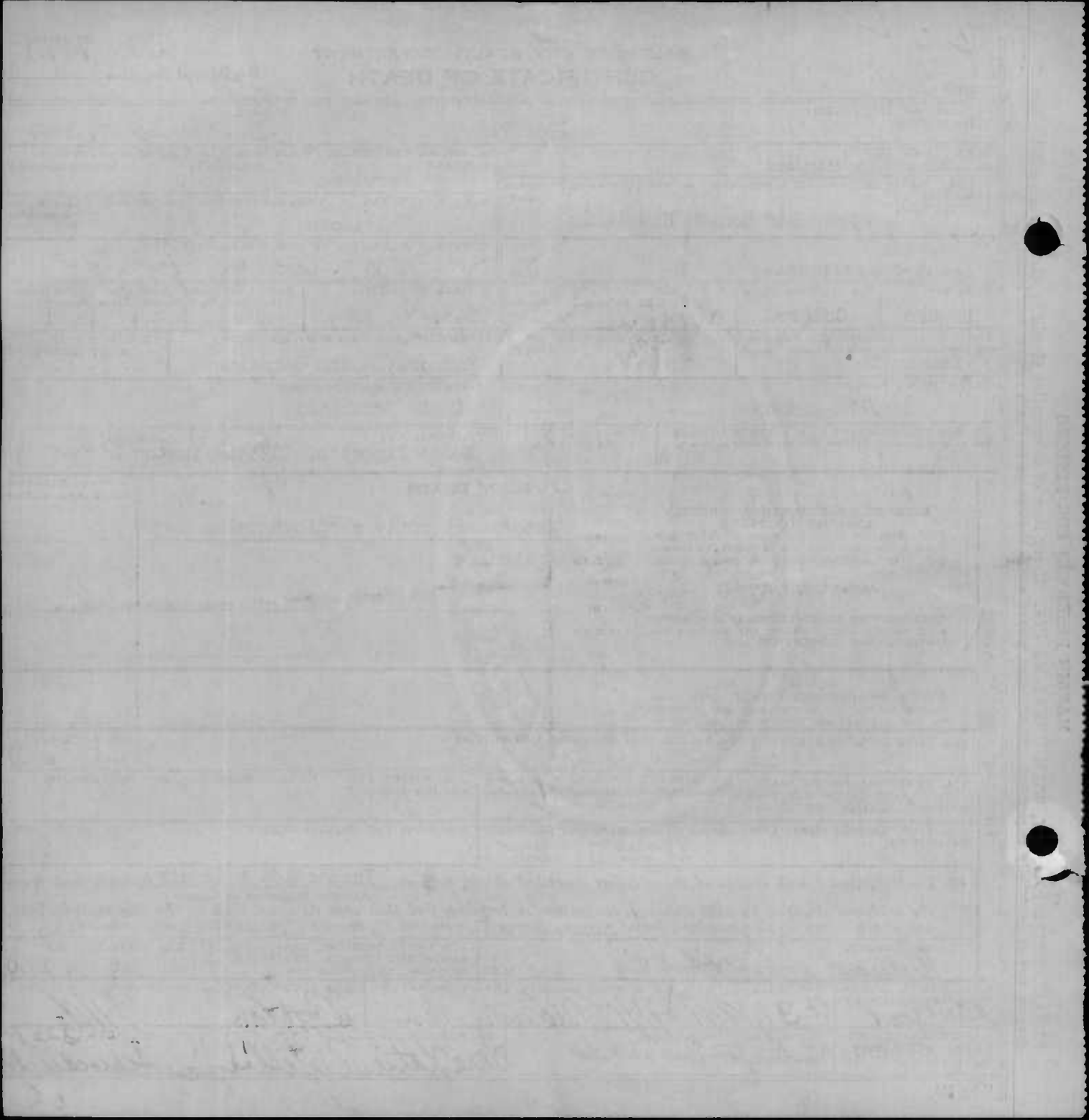
| | | |
|---|--|----------------------------------|
| 18. 4221 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|----------------------------------|

| | | | | |
|---|--|--|--|---|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I took charge of the remains described above, held an <u>Inspection & Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | |

| | | | | |
|--|-------------------------------|--|--|--|
| 23A. SIGNATURE <i>William V. Smith</i> | | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> | | 23C. DATE SIGNED August 28, 1950 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-31-1950 | 24C. NAME OF CEMETERY OR CREMATORY St. Charles Cem | 24D. LOCATION (City, town, or county) (State) Balto. Md. | 25. FUNERAL DIRECTOR Mrs. Katie R. Williams, Schroeder |
| DATE RECEIVED BY LOCAL REGISTRY AUG 29 1950 | | REGISTRAR'S SIGNATURE <i>Franklin Square Hospital</i> | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 7480

BIRTH NO. 49-00537

1. NAME OF DECEASED
(Type or Print)

SUSAN M. HEILAND

2. DATE
OF
DEATH

Aug. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

(before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1156 Ward Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21-02

D. STREET ADDRESS (If rural, give location)

1156 Ward Street

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

child

8. DATE OF BIRTH

Jan. 11, 1949

9. AGE (In years

last birthday)

2 yr.

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H Heiland

14. MOTHER'S MAIDEN NAME

Anna May Goodrich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. John H. Heiland

ADDRESS
1156 WARD
ST. BALTO.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

CAUSE OF DEATH.

Congenital Hydrocephalus

INTERVAL BETWEEN ONSET AND DEATH

19 mos

ANTECEDENT CAUSES

(B)

DUE TO

none

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

none

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8/12/50 to 8/29/50, that I last saw the deceased alive on 8/29/50, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin Miller

M. D.

23B. ADDRESS

2030 Wilbur Ave

23C. DATE SIGNED

8/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

AUG 30 1950

REGISTRAR'S SIGNATURE

Lutington Williams, M.D.

25. FUNERAL DIRECTOR

George L. Schowb

ADDRESS

Fredrick Rd.

200 10 100

100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100

100 100 100 100 100

100 100

100 100 100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 7481

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Juliana Buda

2. DATE
OF
DEATH

Aug. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1913 Cutaw Place

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

25-05

D. STREET ADDRESS (If rural, give location)

1607 Locust St.

C. Length of stay in Baltimore

D. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 15, 1876

9. AGE (In years last birthday)

74

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Austria - Hungary

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Steger - 1607 Locust St.

1B. Y60X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerosis, generalized.

2 yrs

DUE TO

ANTECEDENT CAUSES

diabetes mellitus

sev yrs.

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) also mid thigh amputation rt leg

sev yrs ago

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

senile psychosis
auricular fibrillation

6 mos.

6 months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1, 1950 to Aug 27, 1950, that I last saw the deceased alive on Aug 25, 1950, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

E. Alsworth Cook

M.O.

23B. ADDRESS

2431 Maryland Ave.

23C. DATE SIGNED

8/29/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/30/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

A.A. Co.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Hymn & Fleming - 1426 Light St.

ADDRESS

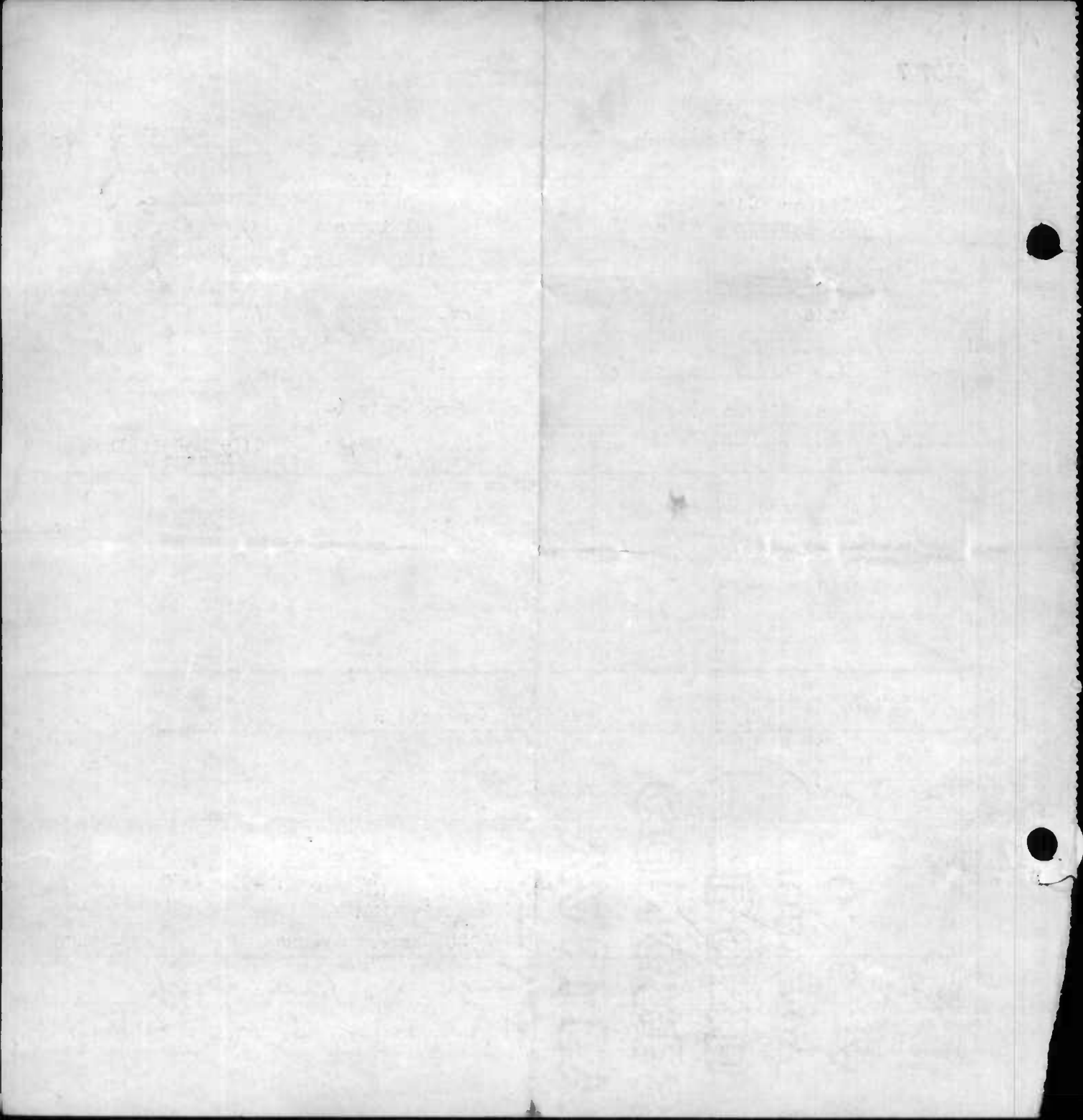
LC 113707 50 7482 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

| | | | | | |
|---|----------------------------------|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) Ralph Milano | | | 2. DATE OF DEATH August 29, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-03 | | |
| c. Length of stay in Baltimore 40 Years Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 2120 Ashland Avenue | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced | 8. DATE OF BIRTH Nov. 28, 1913 | 9. AGE (in years last birthday) 37 | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILE SETTER | | 10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 13. FATHER'S NAME Michael Milano (D) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 14. MOTHER'S MAIDEN NAME Mary Conto (D) | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Baltimore City Hospitals Records* 4940 Eastern Avenue | | |

| | | | | | |
|---|--|--|---|---|--|
| 18. 581.0 DISEASE OR CONDICTION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver (A) QUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 6 Mos. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) QUE TO (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Congestion | | | 2 Weeks | | |
| 19A. DATE OF OPERATION 2 | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Sept. 9 , 19 47 to Aug. 29 , 19 50 , that I last saw the deceased alive on Aug. 29 , 19 50 and that death occurred at 2:00 AM , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE [Signature] M. D. | | 23B. ADDRESS 4940 Eastern Avenue | | 23C. DATE SIGNED 8-29-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 31, 1950 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 24E. NAME OF CEMETERY OR CREMATORY Huntington Williams, Md. | | 24F. FUNERAL DIRECTOR Philip E. Gough | |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1950 | | 24H. REGISTRAR'S SIGNATURE [Signature] | | 24I. ADDRESS 2716 E. Monument St. | |



F-516

50 7483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7483

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Moses Feinberg

2. DATE
OF
DEATH

8-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Sinai Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore township)

14-03

D. STREET ADDRESS (If rural, give location)

1814 Eutaw Place

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 30, 1887

9. AGE (In years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Proprietor

10B. KIND OF BUSINESS OR
INDUSTRY

Jewelry

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Joseph Feinberg

14. MOTHER'S MAIDEN NAME

Minnie Caplan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W. W. 1

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Bessie Feinberg-1814 Eutaw Place

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

ASCVI

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK22. I hereby certify that I attended the deceased from 8/27, 1950, to 8/29, 1950, that I last saw the
deceased alive on 8/29, 1950, and that death occurred at 4:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Jerome J. Golden, M.D.

23B. ADDRESS

Sinai Hosp

23C. DATE SIGNED

8/29/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Aug. 30, 1950

Bnai Israel Cong. Cem.

Northern Ave. Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 30 1950

Huntington Williams, M.D.

Sol. Korman & Bros. 1124-26 W. North Ave.

VS 150

29068

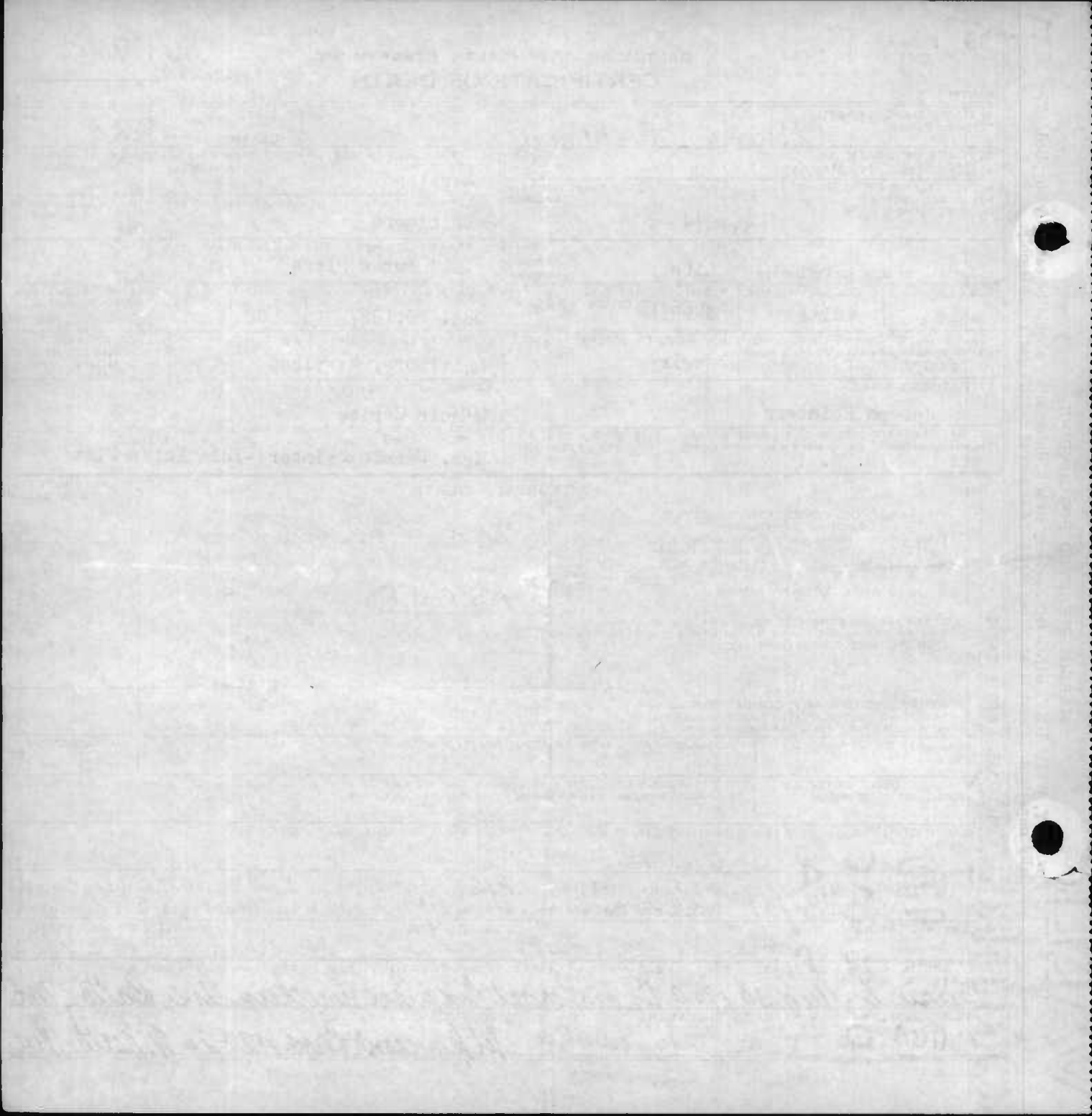
093.4

MARGIN RESERVED FOR BINDING

supplied. The

WITH UNFADING INK. Every item of information should be
correct age is especially important. Physicians: please write the causes of death clearly and leg-PLEASE WRITE IN
correct age is especially

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 7484
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) **MARY E. BAILEY** 2. DATE OF DEATH **August 28, 1950**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **2901 Baker Street** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore **15-06**

D. STREET ADDRESS (If rural, give location)
2901 Baker Street

c. Length of stay in Baltimore **Life** Yrs. _____ Mos. _____ Days _____

5. SEX **Female** 6. COLOR OR RACE **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Widowed** 8. DATE OF BIRTH **Oct. 25, 1868** 9. AGE (In years; last birthday) **82** 10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10B. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (State or foreign country) **Baltimore City** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Nathan Dunbracco** 14. MOTHER'S MAIDEN NAME **Mary E. Jackson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) _____ 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Mrs. Edna B. Eastman** ADDRESS **2901 Baker St**

18. **44-2 X I** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Respiratory failure
DUE TO
Hemiplegia
DUE TO
Arteriosclerotic Cordes Vascular
DUE TO
Renal disease
INTERVAL BETWEEN ONSET AND DEATH _____
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____
19A. DATE OF OPERATION _____ 19B. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) _____ 21E. INJURY OCCURRED _____ 21F. HOW DID INJURY OCCUR? _____
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Aug 27, 1950** to **Aug 28, 1950**, that I last saw the deceased alive on **Aug 27, 1950** and that death occurred at **230 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE **D. H. Brophy M.D.** 23B. ADDRESS **601 N. Howard St** 23C. DATE SIGNED **8/29/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **Aug 30, 1950** 24C. NAME OF CEMETERY OR CREMATORY **Woodlawn** 24D. LOCATION (City, town, or county) **Woodlawn Md.**

DATE RECEIVED BY LOCAL REGISTRAR **AUG 30 1950** REGISTRAR'S SIGNATURE **Wm. H. Williams, M.D.** 25. FUNERAL DIRECTOR **G. Howard Strong** ADDRESS **3207 W. North Ave**

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and in full.

601 N. Monroe St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7485
Registered No.

BIRTH NO.

520
137607

50 7485

1. NAME OF DECEASED
(Type or Print)

Annie Mae Nance

2. DATE
OF
DEATH

August 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR Baltimore City Hospitals location) INSTITUTION

4940 Eastern Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

11-04

D. STREET ADDRESS (If rural, give location)

1213 Madison Avenue (1227)

C. Length of stay in Baltimore

13 yrs.

Yrs.

---Mos.

---Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 14, 1913

9. AGE (in years
last birthday)

37

H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

H. W.

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

N. C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

J. N. Nance

(D)

14. MOTHER'S MAIDEN NAME

Maggie Pittman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Tuberculosis

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

8 Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-27, 1950, to 8-28, 1950, that I last saw the deceased alive on 8-28, 1950, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. B. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

8-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 30 1950

Huntington Williams, M.D.

A. Halstead - 9/8-

H. Halstead - 013.2

VS 150

MARGIN RESERVED FOR BINDING
WITH UNFADING INK. Every item of information should be carefully supplied. The
Physicians: please write the causes of death clearly and legibly.
PLEASE WRITE IN correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7486

BIRTH NO. 50 7486

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED (Type or Print) EARL DILL | | | 2. DATE OF DEATH AUGUST 29, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland FRANKLIN/SQUARE HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 16-03 | | |
| c. Length of stay in Baltimore Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) 1727 W. LANVALE ST. | | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH MAR 6, 1899 | | 9. AGE (In years last birthday) 51 H Under 1 Year Months Days H Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY LABORER | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME ROBERT DILL | | | 14. MOTHER'S MAIDEN NAME CHRISTINE ? | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT FRANKLIN/SQUARE HOSPITAL ADDRESS | | |

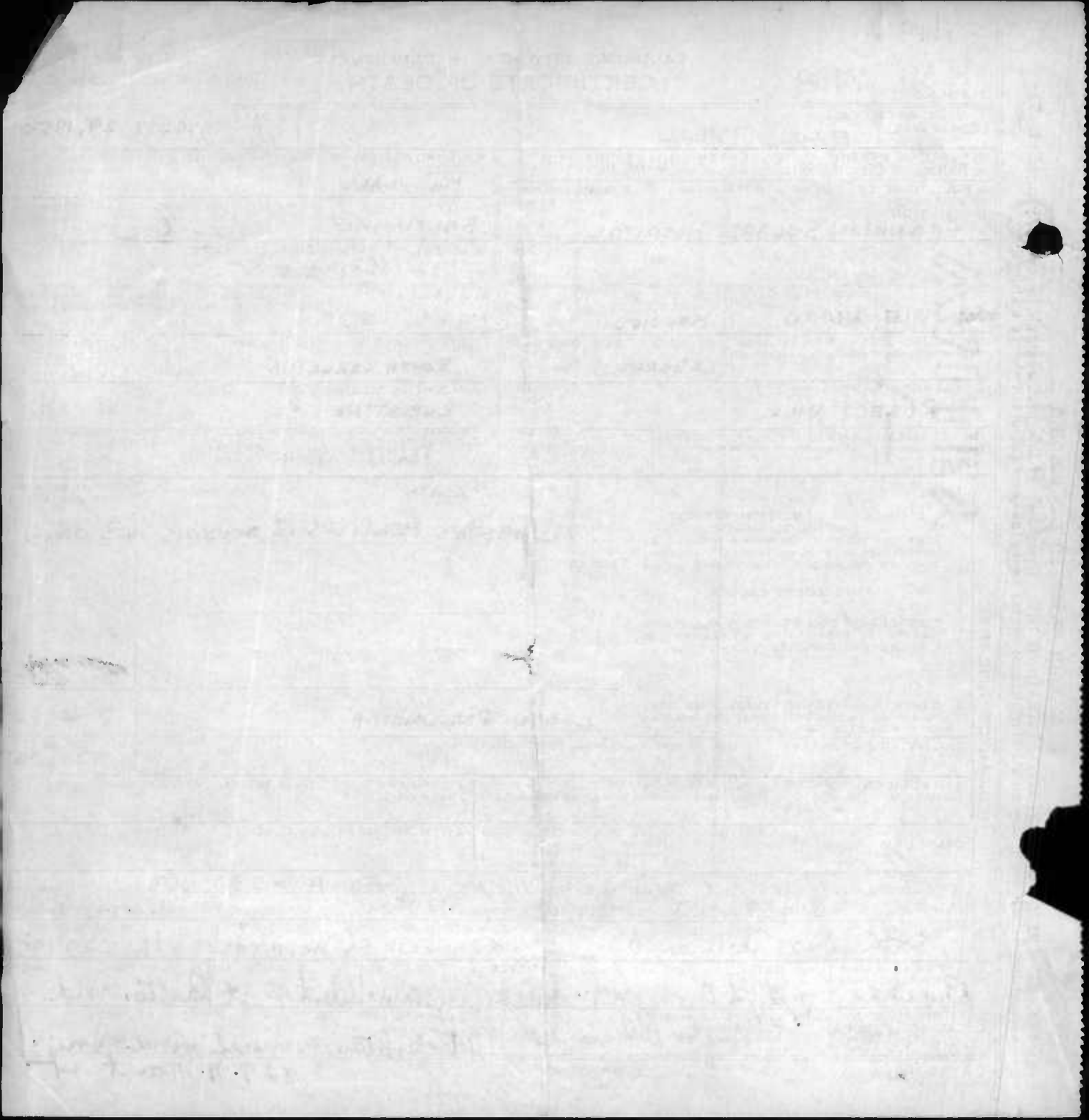
MEDICAL CERTIFICATION

| | | |
|---|---|---|
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DIABETES MELLITUS .2 ACIDOSIS DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. LOBAR PNEUMONIA DUE TO | | |
| (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 2 days. |
| 19A. DATE OF OPERATION 0 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTORSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **AUG 26**, 19**50** to **AUG 29**, 19**50** that I last saw the deceased alive on **AUG 28**, 19**50**, and that death occurred at **12:15 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE **John W. Demand** M.D. 23B. ADDRESS **FRANKLIN Sq HOSPITAL** 23C. DATE SIGNED **AUG 29 1950**

| | | | |
|--|----------------------------|---|---|
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | 24B. DATE 9/2/50 | 24C. NAME OF CEMETERY OR CREMATORY Int. Suburban Cem. West Port Balto. md | 24D. LOCATION (City, town, or county) (State) West Port Balto. md |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1950 | | 25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc. 927 N. Mount St. | |



8-650

50 7487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

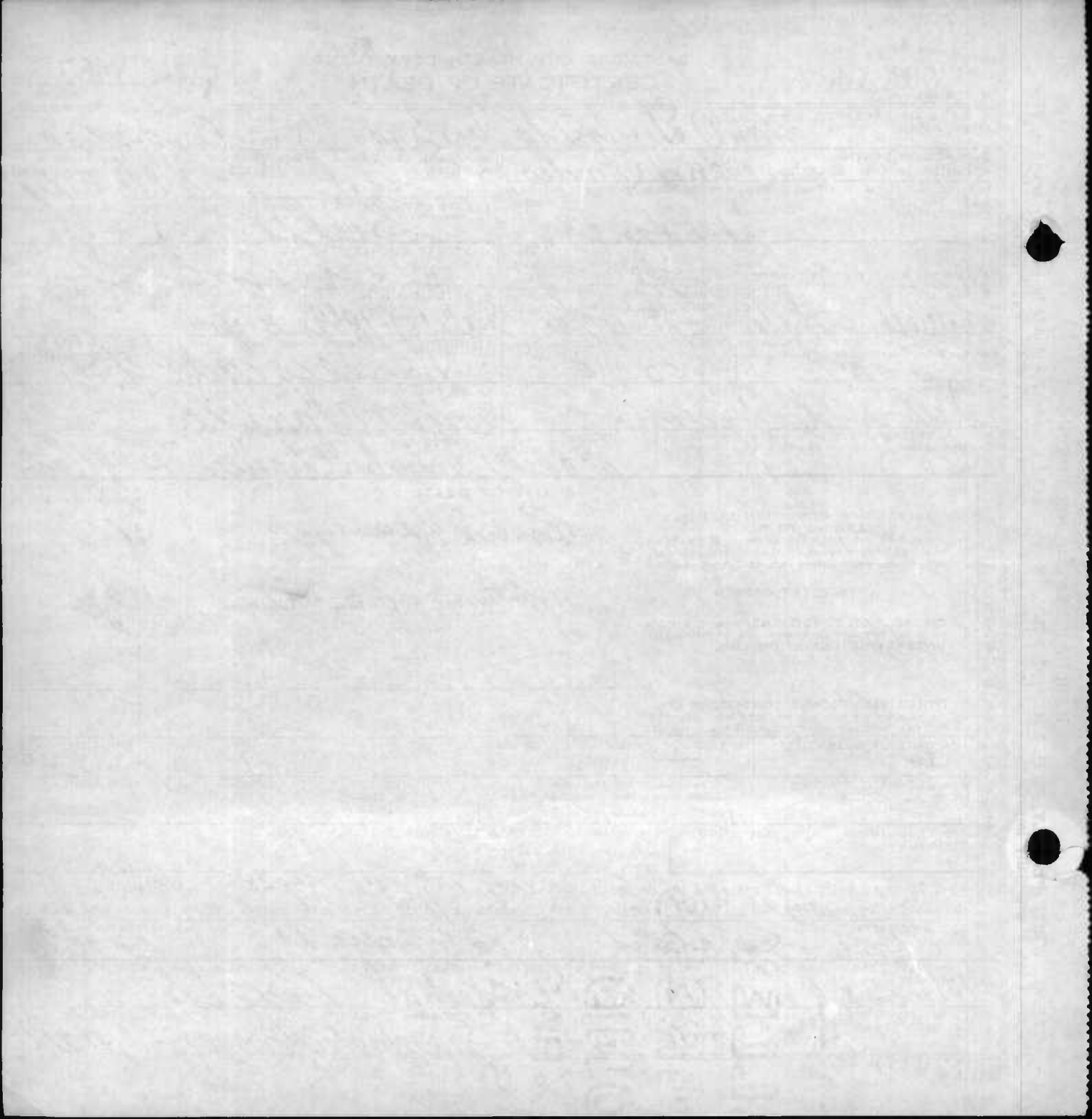
Registered No. 50 7487

| | | | | | |
|---|-------------------------------|--|-------------------------------------|---|-------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Mary Gertrude Irwin</i> | | 2. DATE OF DEATH <i>Aug-28-50</i> | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1128 1/2 Charles</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore City</i> | | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>at home</i> | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>11-02</i> | | | |
| c. Length of stay in Baltimore <i>Life</i> | | D. STREET ADDRESS (If rural, give location) <i>1128 1/2 Charles St</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i> | 8. DATE OF BIRTH <i>July-9-1869</i> | 9. AGE (In years last birthday) <i>81 yrs</i> | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 13. FATHER'S NAME <i>John W. Irwin</i> | | 14. MOTHER'S MAIDEN NAME <i>Emily Claville</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>no</i> | | 17. INFORMANT <i>Mrs. Emily J. Kohler</i> ADDRESS <i>1128 1/2 Charles</i> | |
| 18. <i>331X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Hemorrhage</i> | | CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Hypertension & Arteriosclerosis</i> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>2 yrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>th</i> | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____ | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I hereby certify that I attended the deceased from <i>Aug-10th</i> , 19 <i>50</i> , to <i>Aug 28th</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Aug 28</i> , 19 <i>50</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE <i>H. Chatain</i> | | 23B. ADDRESS <i>15 E. Bell St</i> | | 23C. DATE SIGNED <i>Aug 29/50</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Aug 31/50</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore</i> | | 24E. DATE RECEIVED BY LOCAL REGISTRAR | | 25. FUNERAL DIRECTOR <i>Stewart Morris</i> ADDRESS <i>Baltimore</i> | |

AUG 30 1950

083.1

MARGIN RESERVED FOR BINDING
WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
PLEASE WRITE IN correct age is especially important.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7488 Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HELEN ALBERTA ARBUTHNOT

2. DATE OF DEATH Aug. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

5. FULL NAME OF HOSPITAL OR INSTITUTION

60 Ashburton Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

23-03

D. STREET ADDRESS (If rural, give location)

2214 Hanover St. (Reese's Trailer Lot)

C. Length of stay in Baltimore

about 9 years

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 17, 1903

9. AGE (In years, last birthday)

47

10. Under 1 Year Months: Days: Hours: Min.

11. BIRTHPLACE (State or foreign country)

Fairport Harbor, Ohio

12. CITIZEN OF WHAT COUNTRY?

USA

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bookkeeper

10B. KIND OF BUSINESS OR INDUSTRY

Egg and Poultry Bus.

13. FATHER'S NAME

????? Nenno

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

297-07-507

17. INFORMANT

ADDRESS

George W. Draper (son) 5247 St. Charles Av.

18. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Chronic Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Multiple Sclerosis

2

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8/26, 1950 to 8/28, 1950 that I last saw the deceased alive on 8/28, 1950, and that death occurred at 5 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Aug. 31, 1950

Louisa Park

Balt.-Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 30 1950

Loring Evers - 5005 Park Heights Ave.

VS 150

3106A

City.

093.4

10

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7489
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth M. Dunlop

2. DATE
OF
DEATH

Aug. 29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

8. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

4625 Old Frederick Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

28-04

D. STREET ADDRESS (If rural, give location)

5101 Brookgreen Rd.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Feb. 27, 1865

9. AGE (In years last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maine

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Stinefield

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

J. Stanley Dunlop, 5101 Brookgreen Rd

18. 4221

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Cardio-Vascular Disease

10 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Advanced Arterio-sclerosis

10 yr

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arterio-sclerotic Degeneracy

5 yr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1947, to Aug. 29, 1950, that I last saw the deceased alive on Aug. 29, 1950, and that death occurred at 4 P. M., from the causes and on the date stated above.

23A. SIGNATURE

William K. Gallagher

M. D.

23B. ADDRESS

Catonsville-28, Md.

23C. DATE SIGNED

8-29-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 30/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park, 3801 Frederick Rd. Balt.

24D. LOCATION (City, town, or county)

29, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William K. Gallagher

25. FUNERAL DIRECTOR

Harry A. Ditzler

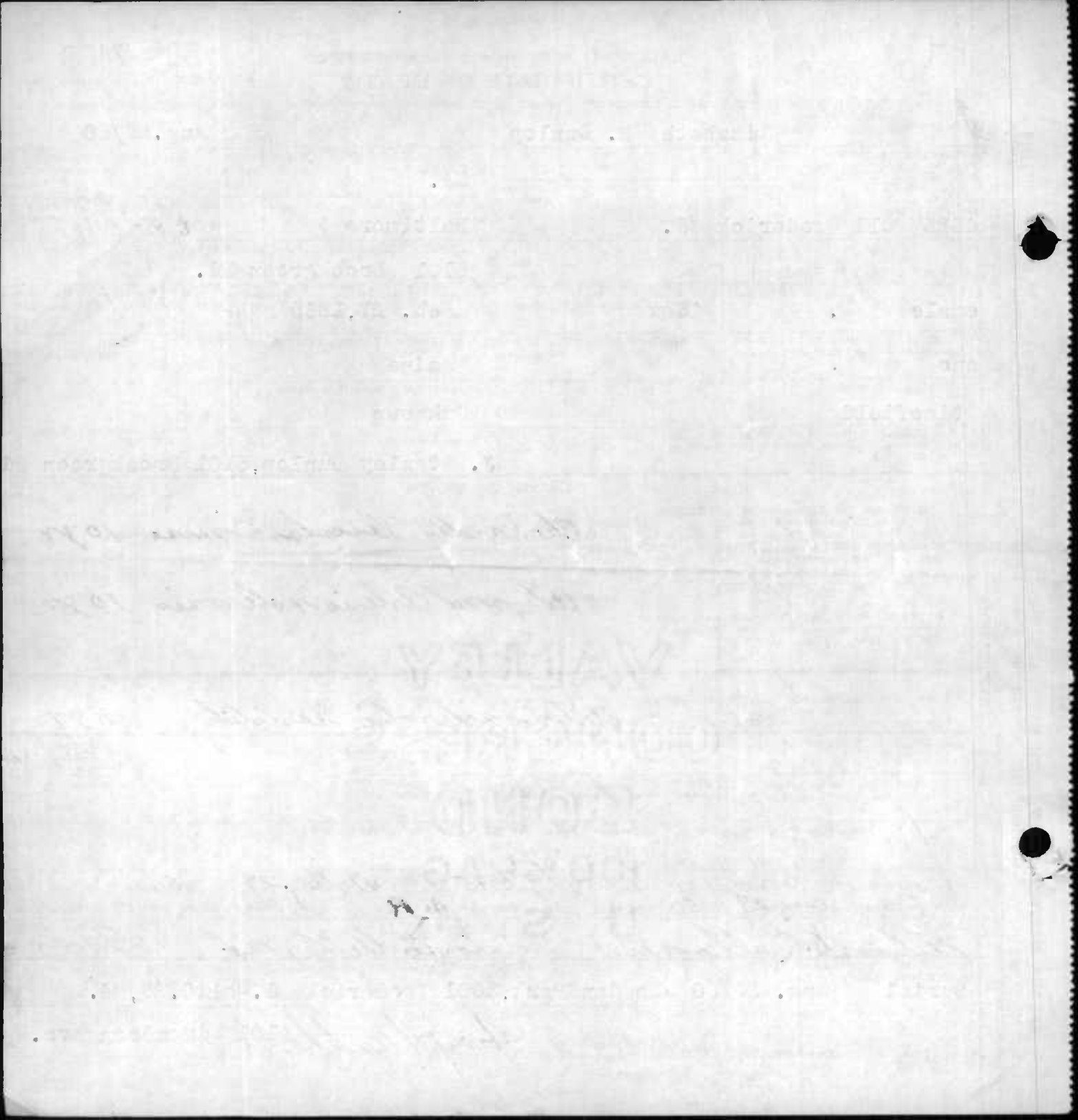
ADDRESS

4101 Edmondson Ave.

AUG 30 1950

VS 150

093.4



B-650
50 7490BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7490
Registered No.

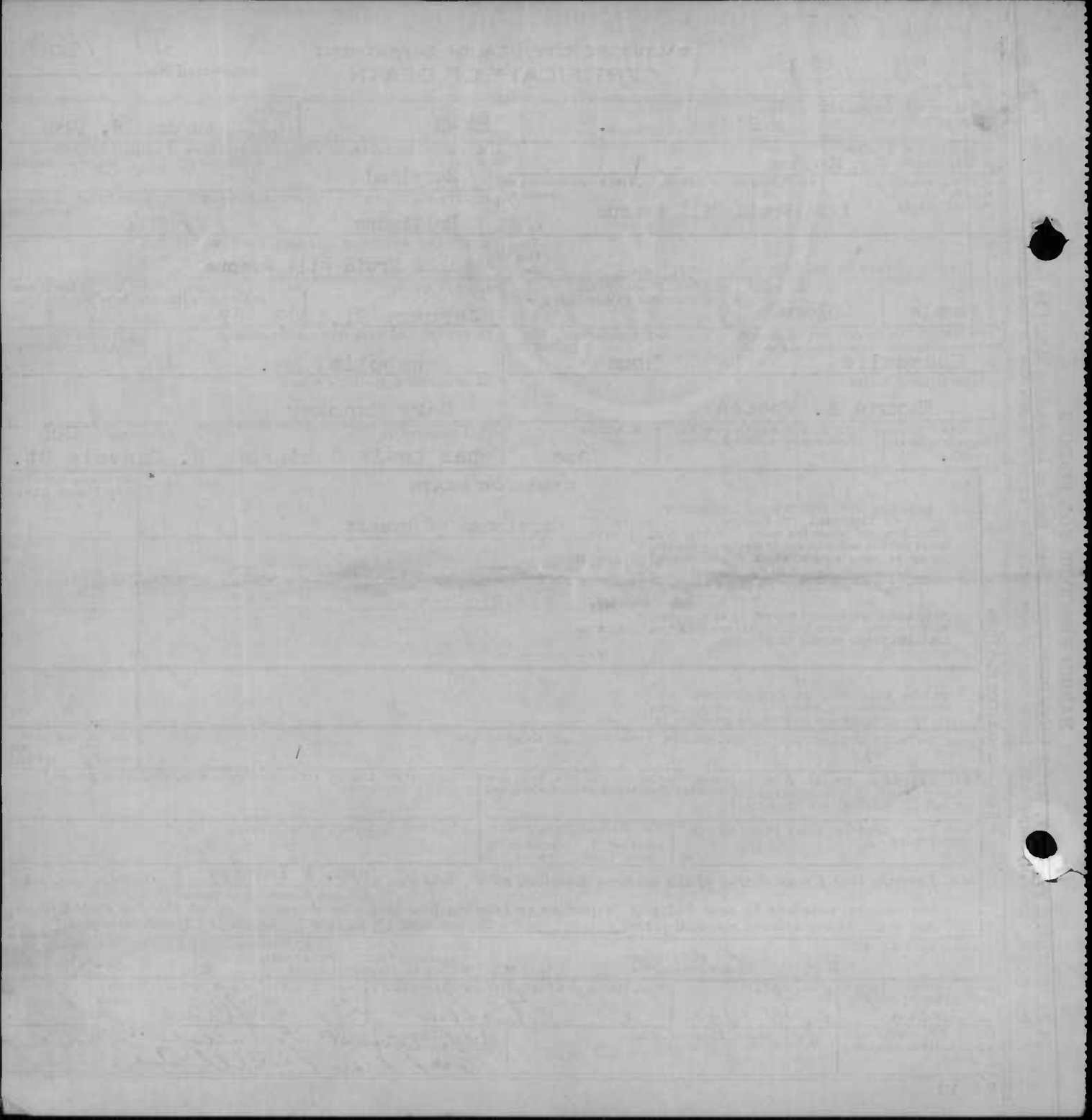
BIRTH NO.

| | | | | | |
|---|------------------------------------|--|--|--|-------------------------------|
| 1. NAME OF DECEASED (Type or Print) MARY E. BROWN | | | 2. DATE OF DEATH August 28, 1950 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION 1404 Druid Hill Avenue | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| D. STREET ADDRESS (If rural, give location) 1404 Druid Hill Avenue | | | Yrs. Mos. Days | | |
| c. Length of stay in Baltimore 50 yrs | | | 8. DATE OF BIRTH January 31, 1883 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 9. AGE (In years last birthday) 67 | | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Annapolis, Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Thomas A. Wooten | | | 14. MOTHER'S MAIDEN NAME Mary Manokay | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Agnes Lewis Robinson | | |
| ADDRESS 806 W. Lanvale St. | | | | | |

| | |
|---|----------------------------------|
| 18. 170X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of breast (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH |
|---|----------------------------------|

| | | | | | |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I took charge of the remains described above, held an <u>Insp. & Inquiry</u> thereon and from <u>Autopsy, Inspection or Inquiry</u> the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . | | | | | |
| 23A. SIGNATURE <i>R. J. Schick</i> | | 23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR..... <input checked="" type="checkbox"/> | | 23C. DATE SIGNED 8-29-50 | |

| | | | |
|--|-----------------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept. 1, 1950 | 24C. NAME OF CEMETERY OR CREMATORY St. Stephen Bock, River Mt. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| DATE RECEIVED BY LOCAL REGISTRAR Aug 30 1950 | | REGISTRAR'S SIGNATURE <i>William H. Williams, M.D.</i> | |
| 25. FUNERAL DIRECTOR Funeral Home | | ADDRESS 1601 Druid Hill Ave | |



A-352

50 7491

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7491
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

ADAMS

2. DATE
OF
DEATH

August 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)A. STATE
Maryland

B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1525 McCulloh Street

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 9, 1917

9. AGE (In years
last birthday)

33

10. Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

School

10B. KIND OF BUSINESS OR
INDUSTRY

U.S. Veteran

11. BIRTHPLACE (State or foreign country)

Phila. Pa.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World 2

16. SOCIAL
SECURITY NO.

17. INFORMANT

Hattie Hamilton

ADDRESS 1525

McCulloh Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Stab wound of abdomen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Internal hemorrhage

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1523 McCulloh Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

August 26, 1950 11:00 Pm.

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Sharp instrument

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

Stanley R. Dunlacher

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
8-28-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial Aug 31, 1951

Bald. National

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 30 1950

Huntington Williams, M.D.

Hallard Funeral Home
1631 Druid Hill Ave.

VS 151

N-868.2

167.0

DEATH RECORD

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|------|--|-----|--|-----|--|------|--|----------|--|----------------|--|------------|--|----------------|--|---------------|--|----------------|--|---------------|--|------------------------|--|------------------------|--|----------------------|--|
| Name | | Age | | Sex | | Race | | Religion | | Marital Status | | Occupation | | Cause of Death | | Date of Death | | Place of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 7492

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Viole Virginia Kelley*2. DATE
OF
DEATH*August 28 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore City*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE *B* B. COUNTY *Maryland*

B. FULL NAME OF HOSPITAL OR INSTITUTION

1824 Linden Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 14-01

D. STREET ADDRESS (If rural, give location)

1824 Linden Ave

C. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

May 17 1894

9. AGE (In years last birthday)

56

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

House wife

11. BIRTHPLACE (State or foreign country)

Baltimore Ind.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Frank Benner

14. MOTHER'S MAIDEN NAME

Martha Mary Tieferman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no.

16. SOCIAL SECURITY NO.

no

17. INFORMANT

Harry M. Kelley 1824 Linden Ave

ADDRESS

18.

330X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Central Hemorrhage*
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Subarachnoid Hemorrhage*
DUE TO*March 1950*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *March 1950* to *Aug 28 1950*, that I last saw the deceased alive on *Aug 28 1950* and that death occurred at *12:00 p.m.* from the causes and on the date stated above.

23A. SIGNATURE

Albert Scagnetti M. D.

23B. ADDRESS

1727 W. Lombard St

23C. DATE SIGNED

8-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial**August 31**Louisa Park**Balt. City**Ind.*

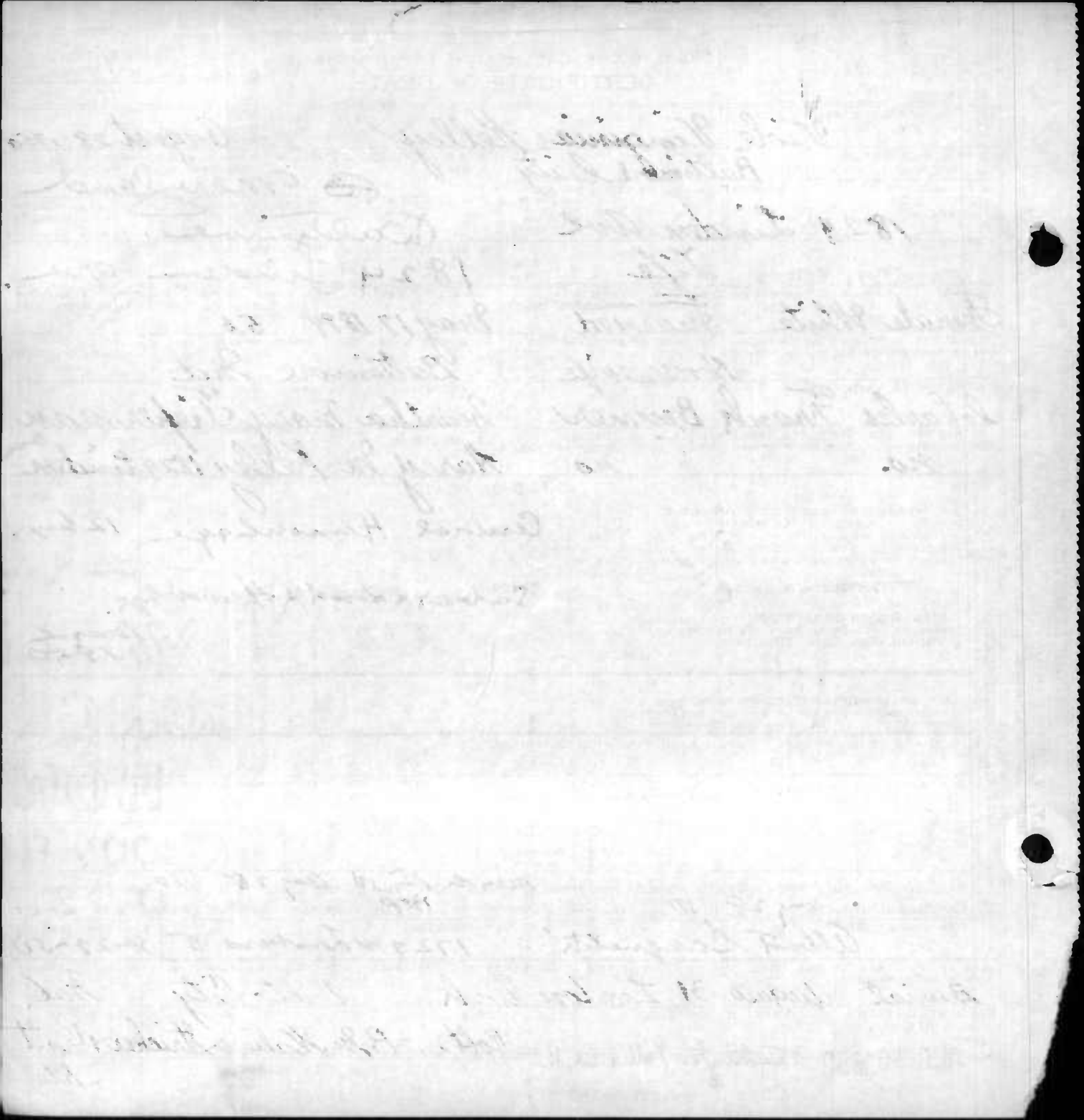
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*AUG 30 1950**Huntington Williams, M.D.**Robt L. & B. M. Walters Stricker & Pratt**083.1 Sts*



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **50 7493**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHESTER

LOUIS

(BREEN) BRENN

2. DATE
OF DEATH

August 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1407 W. Fayette Street

c. Length of stay in Baltimore

14 yrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 23, 1911

9. AGE (In years

39

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shreaper

10B. KIND OF BUSINESS OR INDUSTRY

Paca Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Franklin, Louisiana

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frederick Brenn

14. MOTHER'S MAIDEN NAME

Camelia Moliason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

213-01-2503

17. INFORMANT

Ella A.E. Brenn

ADDRESS

1407 W. Fayette Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William V. Williams*23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
M.D. MEDICAL INVESTIGATOR23C. DATE SIGNED
8-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

August 31

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

3801 Frederick Ave. Inc

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William V. Williams, M.D.

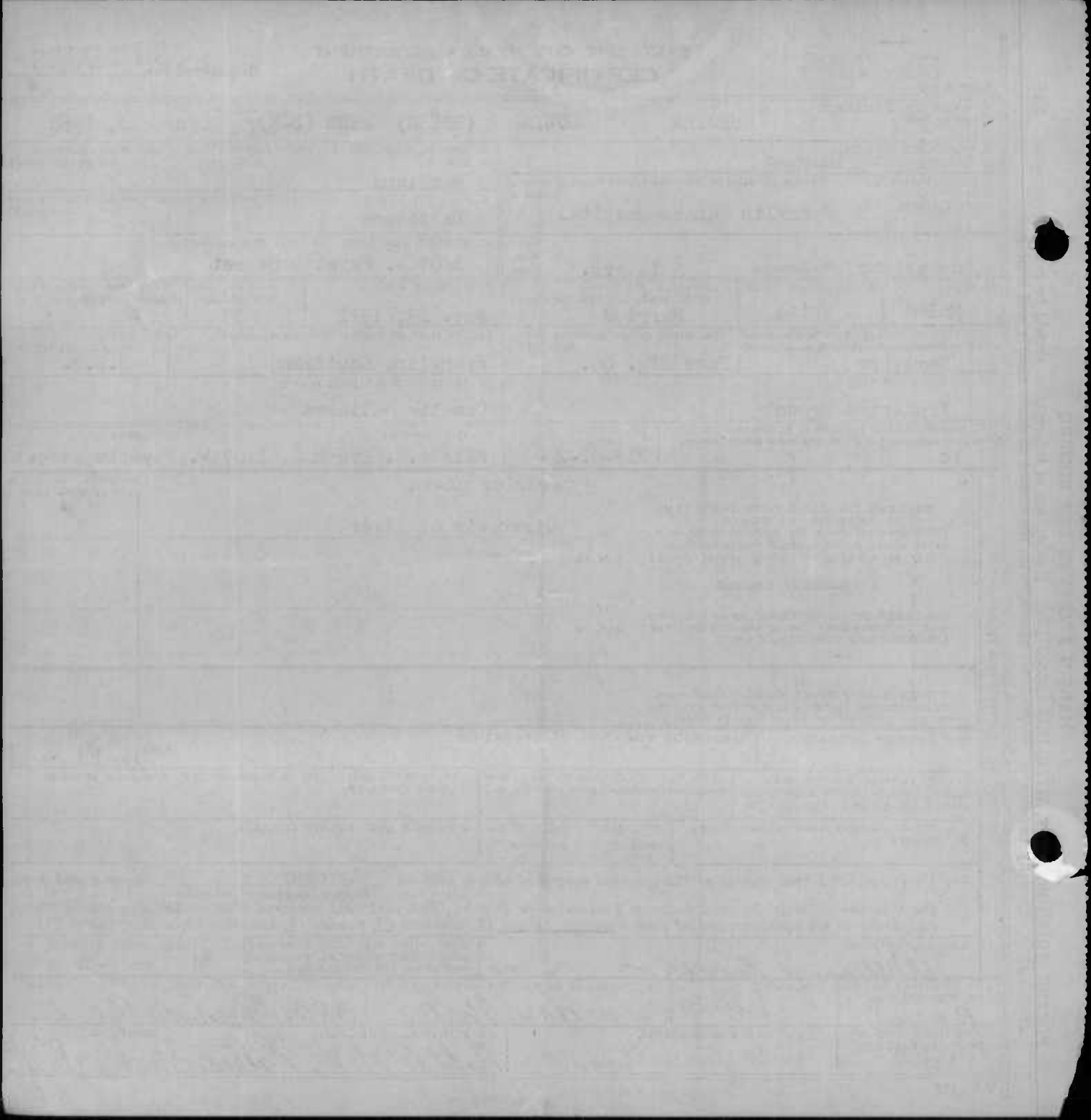
25. FUNERAL DIRECTOR

Robt. C. & B. Walters, Strucker & Pratt

ADDRESS

6904H

124-2 V St



G640

50 7494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7494

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Crowley, Mrs. Ellen Magdalen

2. DATE
OF
DEATH

August 28, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-10

D. STREET ADDRESS (If rural, give location)

510 Radnor ave

c. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/28/1875

9. AGE (In years
last birthday)

75

H Under 1 Year
Months: Days: H Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Hwfe

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John McKeen

14. MOTHER'S MAIDEN NAME

Ellen M.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

Edward B. Crowley

ADDRESS

Same

18.

331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

Hypertension

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Lobar Pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 8-26-50, to 8-28-50, 1950 that I last saw the
deceased alive on 8-28-50, and that death occurred at 9 P. m., from the causes and on the date stated above.

23A. SIGNATURE

John Joseph Krejci

M. D.

23B. ADDRESS

1400 N. Caroline St.

23C. DATE SIGNED

8-28-50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Sept 1, 1950

New Cathedral

Balt., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Harry J. Ginter & Sons 4905 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN FADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY REPORT

PLANT INDUSTRY REPORT

PLANT INDUSTRY REPORT

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PLANT INDUSTRY REPORT

G-652
50 7495BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 7495

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HARRY J. GRINES

2. DATE
OF
DEATH

8-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

23

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

UNIVERSITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

19-03

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

119 S. Helmer St

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

5/2/1980

9. AGE (In years last birthday)

70

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

B & O R R

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James Grines

14. MOTHER'S MAIDEN NAME

Josephine King

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

HOSP. RECORD

ADDRESS

18.

260X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-28, 1950, to 8-29, 1950, that I last saw the deceased alive on 8-29, 1950, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John W. Storer

M. D.

23B. ADDRESS

Alver. 9600p.

23C. DATE SIGNED

8-29-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial
DATE RECEIVED BY LOCAL REGISTRAR

24B. DATE

9/1/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem

24D. LOCATION (City, town, or county)

4300 Old Frederick St.

REGISTRAR'S SIGNATURE

Trentington Williams, M.D.

25. FUNERAL DIRECTOR

John J. Cowan & Son 22 Hollins St.

ADDRESS

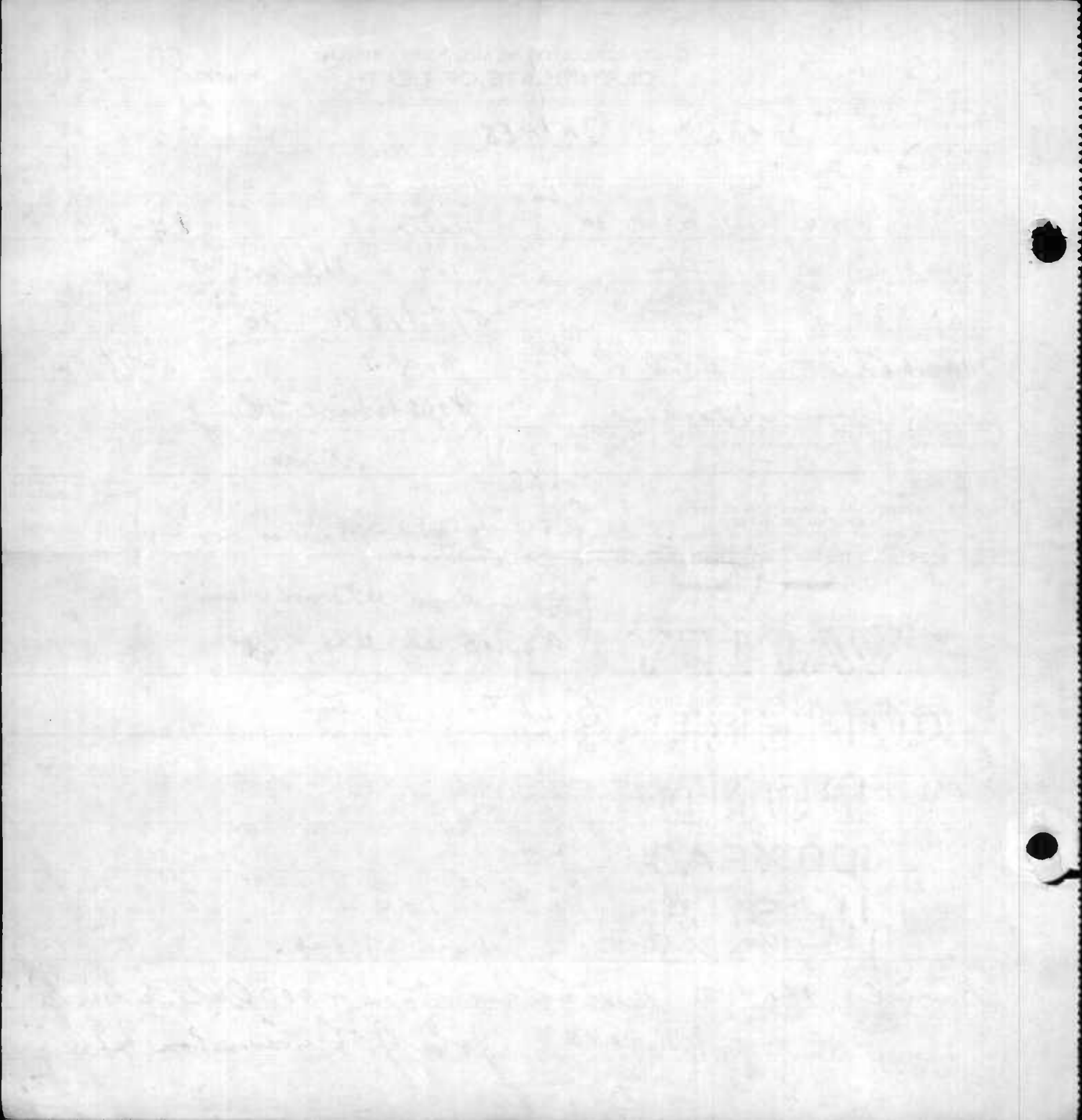
AUG 30 1950

544 50

061.0 St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



J-520
50 7496BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7496

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Georgia Jones

2. DATE
OF
DEATH

Aug. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7-27-89

9. AGE (In years last birthday)

61

10. Under 1 Year 11. Under 24 Hours

Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W. Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George Weale

14. MOTHER'S MAIDEN NAME

Sarah Carney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

204.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident
DUE TO — intracerebral hemorrhage
(B) chronic Myelogenous leukemia
DUE TO
(C)

10 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Secondary anemia - myelophthisic

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/18, 1950, to 8/28, 1950, that I last saw the deceased alive on 8/28, 1950, and that death occurred at 2 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Thomas J. Walsh

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

8-29-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-1-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

A. D. County, Md

DATE RECEIVED BY LOCAL REGISTRAR

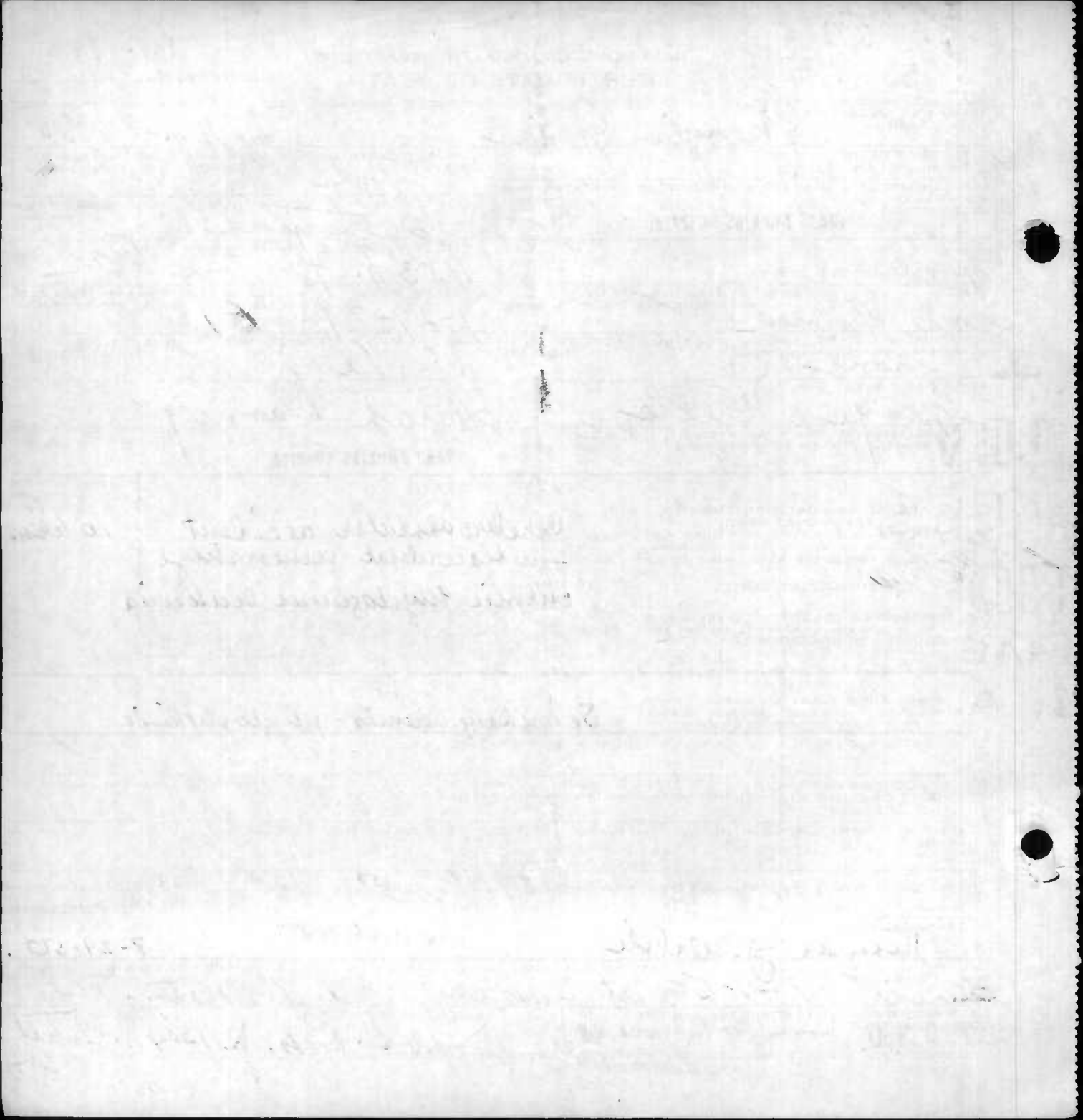
REGISTRAR'S SIGNATURE

Mary G. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph S. Rock, Jr. 1304 N. Central



2-000
50 7497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 50 7497
Registered No.

| | | | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|--------------------------------|---------------------------------|
| BIRTH NO. | | | 1. NAME OF DECEASED (Type or Print) ANNA BERTHA LAY | | | 2. DATE OF DEATH AUG 29 1950 | | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | | | | |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) FALLSTON 62-00 | | | | | | |
| c. Length of stay in Baltimore 002 Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) | | | | | | |
| 5. SEX F | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | | 8. DATE OF BIRTH JULY 10, 1901 | | 9. AGE (In years last birthday) 49 | | H Under 1 Year Months: Days | I Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME WILLIAM MORRIS | | | 14. MOTHER'S MAIDEN NAME ANNA CANTLER | | | 17. INFORMANT ADDRESS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | | 16. SOCIAL SECURITY NO. | | | | | | |

| | | | | | |
|---|--|--|--|----------------------------------|--|
| 18. 022X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) MASSIVE GASTROINTESTINAL HEMORRHAGE | | 36hr | |
| ANTECEDENT CAUSES | | DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) EROSION OF AORTIC ANEURYSM | | | |
| | | DUE TO | | INT. ESOPHAGUS | |
| II | | (C) SYPHILIS | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. | | | | | |

| | | | | | |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Aug 27, 1950 to Aug 29, 1950 that I last saw the deceased alive on Aug 29, 1950 , and that death occurred at 1:45 p.m. , from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE Francis H. Watt | | 23B. ADDRESS M. O. Union Memorial Hosp. | | 23C. DATE SIGNED 8-29-50 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 1-50 | | 24C. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Garden | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25. FUNERAL DIRECTOR Joseph F. Foster | | ADDRESS Bel Air Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1950 | | REGISTRAR'S SIGNATURE William M. ... | | | |

MARGIN RESERVED FOR BINDING
WITH UNFADING INK. Every item of information should be carefully supplied. The important. Physicians: please write the causes of death clearly and legibly.
PLEASE WRITE IN correct age is espec.

To be approved by Medical Examiner
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. **50 7498**

BIRTH NO. **150 7498**

| | | | | | |
|---|----------------------------------|---|--|--|------------------------------|
| 1. NAME OF DECEASED (Type or Print) Eric Kohlman | | | 2. DATE OF DEATH 8/29/50 | | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Delaware B. COUNTY | | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bridgeville, Delaware | | |
| c. Length of stay in Baltimore one Yrs. Mos. Days | | | D. STREET ADDRESS (If rural, give location) Walnut Street V-07 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Feb 26, 1907 | 9. AGE (In years last birthday) 43 | 10. Under 1 Year Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool worker | | | 11. BIRTHPLACE (State or foreign country) Michigan | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Louis Kohlman | | | 14. MOTHER'S MAIDEN NAME Mary Hall | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Francis Kohlman | | | ADDRESS Same - | | |

| | | |
|--|--|---|
| 18. 526 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Air embolism following Bronchoscopy | | INTERVAL BETWEEN ONSET AND DEATH 1/2 hour |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Bronchiectasis - | | 11 years |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY
R. Fisher M.D.
CHIEF OF MED. STAFF, CORNER

| | | | | |
|---|-------------------------------|--|---|--|
| 19A. DATE OF OPERATION 8/29/50 | | 19B. MAJOR FINDINGS OF OPERATION Bronchiectasis | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) University Hospital, Redwood & Greene |
| 21D. TIME (Month) (Day) (Year) (Hour) August 29, 1950 3:00P.m. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Patient collapsed following bronchoscopy. Apparently ruptured lung by coughing |
| 22. I hereby certify that I attended the deceased from 8/29, 1950 , to 8/29, 1950 , and that death occurred at 3:30 pm from the causes and on the date stated above. | | | | |
| 23A. SIGNATURE Thomas D. Michael M.D. | | 23B. ADDRESS University Hospital | | 23C. DATE SIGNED 8/29/50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept 1-50 | 24C. NAME OF CEMETERY OR CREMATORY Bridgeville | 24D. LOCATION (City, town, or county) (State) Bridgeville, Delaware | |
| DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1950 | | 25. FUNERAL DIRECTOR Harvey Williamson, Federalburg, Md. | | |

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12/15/50

F-630
REA 141006BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 7499
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Robert Edgar Ford

2. DATE
OF
DEATH

August 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTE Baltimore City Hospitals location)
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore township)

D. STREET ADDRESS (If rural, give location)

1501 E. Lafayette Ave

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
widowed

8. DATE OF BIRTH

Dec 16, 1878

9. AGE (in years

last birthday)

71

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Ford (D)

14. MOTHER'S MAIDEN NAME

Harriett Lee (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchiogenic Carcinoma with
Metastasis to the lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDuration
UnknownII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 25, 1950 to August 28, 1950, that I last saw the
deceased alive on August 28, 1950 and that death occurred at 11:40 AM, from the causes and on the date stated above.

23A. SIGNATURE

W. C. Cogan

M. D.

23B. ADDRESS

4940 Eastern Ave

23C. DATE SIGNED

August 28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Aug 31/1950

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Baltimore Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Luntington Williams, M.D.

25. FUNERAL DIRECTOR

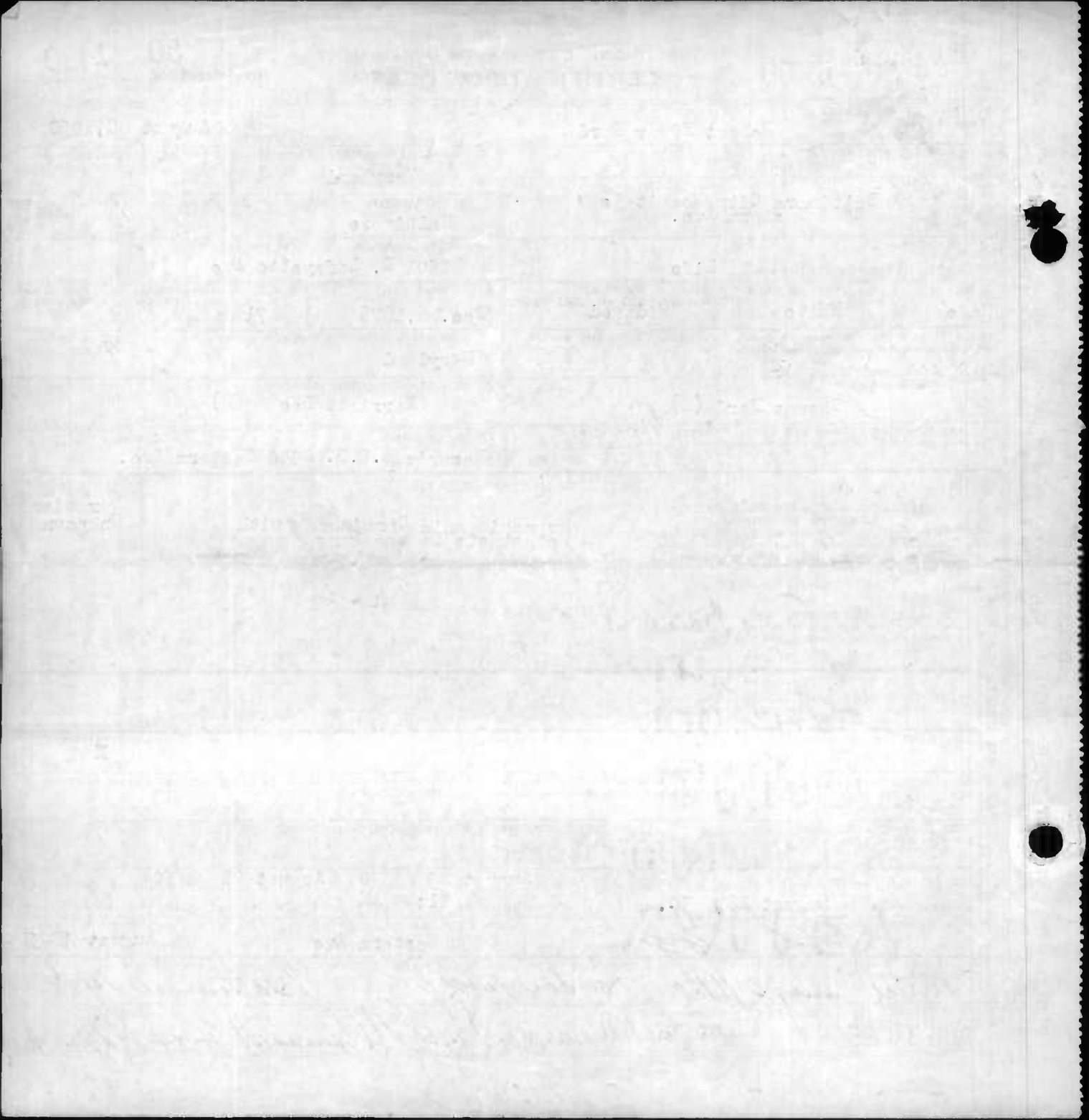
ADDRESS

4204 Ridgewood

VS 150

574 24

047.3



G-453
50 7500BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 7500

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH S. GUILMETTE

2. DATE

OF DEATH

Aug. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

4-01

D. STREET ADDRESS (If rural, give location)

234 N. Eutaw St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

234 N. Eutaw St.

Yrs.

Mos.

Days

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 17, 1875

9. AGE (In years

last birthday)

75

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Entainer, Actor

10B. KIND OF BUSINESS OR INDUSTRY

Carlins Park

11. BIRTHPLACE (State or foreign country)

Canada

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Xa vier Guilmette

14. MOTHER'S MAIDEN NAME

Margaret Guilmette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-12-2463

17. INFORMANT

ADDRESS

Margaret Guilmette, 234 N. Eutaw St.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

My condition
Arteriosclerosis
Fibrillation (cardiac). Aug/49.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1948, to Aug 28, 1950, that I last saw the deceased alive on Aug 28, 1950, and that death occurred at 4 A. m., from the causes and on the date stated above.

23A. SIGNATURE

N. B. Thiele

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/31/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 30 1950

William Williams, M.D.

1214 St Paul St

VS 150

093.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

